High Desert Chiropractic & Massage

Brandi Kuhn, DC,CCSP Joshua Kuhn, DC Jeremy Holbrook, DC

Patient Information

Date_____
Patient_____
Address_____
_____
Sex: M F Age_____ Birthdate_____
Referral:_____
Email:_____

☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Partnership

Patient SS#_____
Occupation_____
Employer_____
Employee Address_____
Employer Phone_____
Spouse's Name_____

Account

Who is responsible for this account?_____

Will this account be paid by Cash or Insurance

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Phone Numbers

Home_____Work_____Cell_____
Best time and place to reach you?_____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____
Home Phone_____
Work Phone_____Ext._____
Cell Phone_____

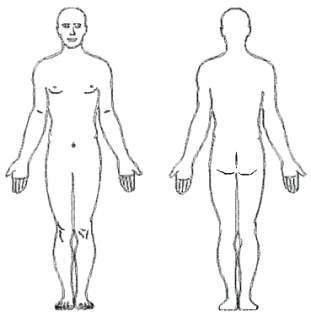
Accident Information

Is condition due to an accident?_____
Date_____
Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your Accident?
☐ Auto Insurance ☐ Worker Comp
☐ Employer ☐ Other
Attorney Name and Address (if applicable)
_____
_____

Patient Condition

Reason for visit_____
When did your symptoms appear_____
Is this condition getting progressively worse? Yes, No, Unsure
Mark an X on the picture where you continue to have pain, numbness or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____
Type of pain: sharp, dull, throbbing, numbness, aching, shooting , burning, tingling, cramps, stiffness, swelling, other _____
How often do you have this pain?_____
Is it constant or does it come and go?_____
Does it interfere with your: work, sleep, daily routine, recreation
Activities or movements are painful to perform: sitting, standing, walking, bending, lying down, other _____
_____



1551 NE 4th St., Bend, Oregon 97701 Office (541) 389-9373 Fax (541) 388-0650

HEALTH HISTORY

Name Date

What treatment have you already received for your condition? Medications Surgery Chiropractic Physical Therapy None
Other_____
Name of other doctor (s) who have treated you for your condition_____
Date of last: **Physical Exam**_____ X-rays_____ Blood Test_____
MRI, CT-Scan, Bone Scan_____ Urine Test _____
Place a circle on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Mononucleosis	Yes	No	Rheumatoid Arthritis	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Multiple Sclerosis	Yes	No	Rheumatic Fever	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Mumps	Yes	No	Scoliosis	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Osteoporosis	Yes	No	Stroke	Yes	No
Anorexia	Yes	No	Glaucoma	Yes	No	Pacemaker	Yes	No	Thyroid Problem	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Parkinson's Disease	Yes	No	Tuberculosis	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Pinched Nerve	Yes	No	Tumors, Growth's	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Pneumonia	Yes	No	Typhoid Fever	Yes	No
Bleeding Disorders	Yes	No	Hepatitis	Yes	No	Polio	Yes	No	Ulcers	Yes	No
Breast Lump	Yes	No	Hernia	Yes	No	Prostate Problem	Yes	No	Whooping Cough	Yes	No
Bronchitis	Yes	No	Herniated Disk	Yes	No	Prosthesis	Yes	No			
Cancer	Yes	No	High Cholesterol	Yes	No	Psychiatric Care	Yes	No			
Cataracts	Yes	No	Kidney Disease	Yes	No	PMS	Yes	No			
Chemical Dependency	Yes	No	Liver Disease	Yes	No						
Chicken Pox	Yes	No	Measles	Yes	No						
			Migraine Headache	Yes	No						

Other_____
***Family Health History (Who in your family has any disease or health problems?) Grandparents_____**
Parents_____ Siblings_____

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking Packs/Day_____
- ☐ Alcohol DrinksWeek_____
- ☐ Coffee/Caffeine Cups/Day_____
- ☐ High Stress Level Reason_____

Are you pregnant? Yes No Due Date_____ Do you have children? Yes No How Many?_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name_____		
Pharmacy Phone_____		

High Desert Chiropractic & Massage

Dr. Brandi Kuhn
Dr. Joshua Kuhn
Dr. Jeremy Holbrook
Dr. Alyssa Salava
Dr. Andreas Stridsland

1551 NE 4th St.
Bend, OR 97701
Office 541.389.9373
Fax 541.388.0650

51538 Hwy 20 Ste 2A
LaPine, OR 97739
Office 541-540-2155

HDChiro@gmail.com
highdesertchiro.com

HIPAA Policy

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with chiropractic services. HIPAA provides certain rights and protections to you as the patient. Additional information is available from the the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services to or to ensure that all administrative matters related to your care are handled appropriately, This specifically includes the sharing of information with other healthcare providers, laboratories and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in the office and will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments via telephone, text message, email or by any means convenient and requested by you. We may send you other communications informing you of changes to office policy that you may find valuable.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI and agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies to insurance payers in normal performance of their duties.
5. You agree to bring any concern or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. You have the right to read, review and copy your health information and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to assemble your copy.
9. You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete.
10. You have the right to request from us a description of how and where your health information was used by our office for any other reason than for the treatment, payment or healthcare operations. Please let us know the time period for which you are interested. We may need to charge you a reasonable fee for your request.
11. We may change, add or delete any of these provisions to better serve serve the needs of both the practice and the patient.
12. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
13. You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised.

Thank you very much for taking the time to review how we are carefully using your health information.

I,_____date_____do hereby consent and acknowledge my agreement to the privacy terms set forth in the this form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____date_____
Witness

High Desert Chiropractic & Massage

Dr. Brandi Kuhn
Dr. Joshua Kuhn
Dr. Jeremy Holbrook
Dr. Alyssa Salava
Dr. Andreas Stridsland

1551 NE 4th St.
Bend, OR 97701
Office 541.389.9373
Fax 541.388.0650

51538 Hwy 20 Ste 2A
LaPine, OR 97739
Office 541-540-2155

HDChiro@gmail.com
highdesertchiro.com

Financial Agreement

As an integral part of our goal to provide thorough, quality care to our patients, a simplified procedure for payment of professional services and insurance billing has been adopted:

1. Please remember that insurance billing is not a substitute for payment. You are expected to keep you account current by paying your co-pay, coinsurance or treatment charge applied to your deductible at the time your treatment is rendered. Payment can be made by either check, cash, Visa, MasterCard, American Express, HSA and FSA cards.
2. If we are billing insurance insurance for you you are responsible for checking that your insurance is paying in a timely manner and that any outstanding balance is paid to High Desert Chiropractic. If your insurance company is not keeping current, it is your responsibility to contact them for payment.
3. You are responsible for all balances your insurance company deems "patient responsibility".
4. Your signature below constitutes authorization for High Desert Chiropractic to to release any required information to your insurance company.
5. Some insurance companies will send payment directly to the patient even though our office has 'accepted assignment" you are responsible for signing the payment over to High Desert Chiropractic.
6. Either a service charge or flat rate fee will be added to the outstanding balance on all accounts that are 30 days past due. You are responsible for any and all collection costs that are incurred as a result of non-payment of your account. A minimum collection fee of $35 will be added to all accounts 90 days past due.
7. A missed appointment fee of $25 will be charged for any appointment cancelled under 24 hours from the scheduled appointment time.

I,_____date_____do hereby consent and acknowledge my agreement to the financial terms set forth in the this form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____date_____
Witness