Fisher Chiropractic
7185 SW Sandburg St., Suite 100
Tigard, OR 97223
(503) 847-2225

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS **requires** providers to report both race and ethnicity*

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit.**

(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date:_____

Height: _____ Weight:_____ Blood Pressure:_____ /_____

Ryan Fisher, D.C., P.C.
Fisher Chiropractic
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HIPAA AUTHORIZATION FORM

permission from patient/patient's legal guardian to share information

Patient Name:_____ DOB:____ /____ /____

I, _____, hereby authorize Fisher Chiropractic and/or any medical facility to release any and all medical information, account details, and test results that pertain to me to the following individual(s):

Name:_____Phone Number: (_____) _____ - _____ Relationship:_____

Name:_____Phone Number: (_____) _____ - _____ Relationship:_____

Name:_____Phone Number: (_____) _____ - _____ Relationship:_____

I understand that I may revoke/cancel this notice at any time by providing Fisher Chiropractic instruction to cancel or change the individual(s) listed on this form, in writing. Any written notices received will supersede this form.

I authorize Fisher Chiropractic to leave detailed messages pertaining to my appointments, billing, or clinical findings at the following phone number(s) or email address(es), if any (please circle phone number type):

Cell/Home/Work/Other: (_____) _____ - _____

Cell/Home/Work/Other: (_____) _____ - _____

Email: _____

Patient Signature: _____Date: _____

Or

Signature of Legal Guardian: _____Date: _____

Witness: _____ Initials: _____ Date: _____

FISHER CHIROPRACTIC
7185 SW Sandburg St. #100
Tigard, OR 97223
503•847•2225 Fax: 503•548•4633

Patient Information

Date: _____ Full Name: _____

Height: _____

DOB: _____ Sex: ◯ Male ◯ Female Weight: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____

◯ Text ◯ Email

Would you like appointment reminders? ◯ Yes ◯ No Cell Carrier: _____

Marital Status: _____ Spouse Name: _____ # of Children: _____

Emergency Contact: _____ Emergency Relationship: _____

Referral Information

How did you hear about us? ◯ Drive-by ◯ Website ◯ Referred by _____

◯ Other _____

Employment Information

◯ Full Time ◯ Part Time ◯ Homemaker ◯ Retired ◯ Student ◯ Unemployed

Occupation: _____

Work Duties: _____

Insurance Information

Company Name: _____

Address: _____ Phone Number: _____

Member ID: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____

Complaint Information

Was there an injury? ◯ Yes ◯ No If yes, describe what happened: _____

_____

Describe discomfort: _____

Frequency: ◯ Always ◯ Hourly ◯ Daily ◯ Occasionally

Does Discomfort:

Interfere with activities? ◯ Yes ◯ No

Affect your sleep? ◯ Yes ◯ No If yes, how so? _____

Keep you from work? ◯ Yes ◯ No If yes, how much time? _____

Affect your appetite? ◯ Yes ◯ No Explain: _____

What aggravates condition? _____

What improves condition? _____

Have you received treatment for condition? ◯ Yes ◯ No Explain: _____

_____

Have x-rays been taken? ◯ Yes ◯ No

Patient Social Information

Alcohol:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Caffeine:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Processed Foods:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Drugs:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Tobacco:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Exercise:	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never

History

Date of Last Physical Exam: _____

Health Conditions: _____

Surgeries (include dates): _____

Medications or Supplements (include doses): _____

_____

Previous Chiropractic Care: ◯ Yes ◯ No How long ago? _____ Frequency: _____

Chance Pregnant: ◯ Yes ◯ No

Broken Bones: ◯ Yes ◯ No If yes, please provide additional details below.

Sprains/Strains?: ◯ Yes ◯ No If yes, please provide additional details below.

Auto Accidents: ◯ Yes ◯ No If yes, please provide additional details below.

Struck Unconscious: ◯ Yes ◯ No If yes, please provide additional details below.

Eating Disorder: ◯ Yes ◯ No If yes, please provide additional details below.

Stroke: ◯ Yes ◯ No If yes, please provide additional details below.

Please provide any additional information to the above questions here: _____

_____

Health Checklist

◯ Allergies	◯ Alcoholism	◯ Anemia
◯ Arteriosclerosis	◯ Arthritis	◯ Asthma
◯ Back Pain	◯ Breast Lump	◯ Bronchitis
◯ Bruise Easily	◯ Cancer	◯ Chest Pain
◯ Cold Extremities	◯ Constipation	◯ Cramps
◯ Depression	◯ Diabetes	◯ Digestion Problems
◯ Dizziness	◯ Excessive Menstruation	◯ Eye Pain or Difficults
◯ Fatigue	◯ Frequent Urination	◯ Headache
◯ Hemmorrhoids	◯ High Blood Pressure	◯ Hot Flashes
◯ Irregular Heart Beat	◯ Irregular Menstrual Cycle	◯ Kidney Infection
◯ Kidney Stones	◯ Loss of Memory	◯ Loss of Balance
◯ Loss of Smell	◯ Loss of Taste	◯ Nosebleeds
◯ Pacemaker	◯ Polio	◯ Poor Posture
◯ Prostate Trouble	◯ Sciatica	◯ Shortness of Breath
◯ Spinal Curvatures	◯ Sinus Infection	◯ Insomnia
◯ Swollen Joints	◯ Stroke	◯ Swelling of Ankles
◯ Ulcers	◯ Thyroid Condition	◯ Tuberculosis
	◯ Varicose Veins	◯ Venereal Disease

◯ Other: _____

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Patient Informed Consent

Patient Name: _____ Date: _____

I, the undersigned, herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapies, physiological therapeutics (e.g. vitamins/mineral supplementation, botanicals, etc.) on me (or the patient named above, for whom I am legally responsible) by Ryan Fisher, D.C., and/or any relief doctor who now or in the future treats me in the office.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some rare risks to treatment, including but not limited to sprains, strains, fractures, strokes, general aggravation of inflammatory conditions, nutrient-drug interactions and nutrient-nature and purpose of chiropractic adjustments and other procedures. I understand that the doctor will perform an exam in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise professional judgments during the course of the procedures which the doctor feels, at the time, based upon the facts as then known, are in my best interest. Finally, I understand that the doctor gives no guarantee or assurance as to the results of the procedures.

In the event the undersigned has a dispute with the doctors or their staff about the quality of service, the undersigned agrees that such dispute shall be submitted to arbitration, according to Title 3, Sections 36.310 et seq of the Remedial Code, Oregon Rules of Civil Procedure, before a neutral arbitrator to be selected by parties or appointed by the court. Arbitration shall occur in Washington County, Oregon, may be compelled by petition of either party to the court and any award resulting from such arbitration shall become binding on the parties upon confirmation by the court. This arbitration clause shall not prevent the doctors from taking any actions in court to collect a debt owed by the undersigned. In the event of arbitration and/or litigation, the prevailing party shall recover reasonable attorney fees from the adverse party.

I have read, or had had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
Patient/Guardian Signature Date

_____ _____
Doctor Signature Date

Fisher Chiropractic

7185 SW Sandburg St., Suite #100
Tigard, OR 9723
503-847-2225

OFFICE PAYMENT POLICY

24 HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS!

In the interest of good health care practice, it is desirable to establish a payment policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end. We require a 24 hour cancellation notice. If you fail to show up at your scheduled appointment time, or call and cancel with less than 24 hours, for either chiropractic or massage, you will be charged the full amount of that visit. In addition, we would like to clarify our policy for the following payers.

Health Insurance: Our office will check your policy for the conditions of your chiropractic coverage. Many policies have a limitation on the number of treatments or other specific limitations. It is your responsibility to be aware of the particulars of your policy. You are financially responsible for all treatment rendered, whether it is covered by insurance or not.

You may pay for your treatments, at the time of each treatment, until we believe that your deductible is met. Then you may pay, at the time of each visit, the percentage that insurance is not expected to cover. We will bill insurance for you and collect their payment. You will then be billed or credited for any discrepancies in the account.

From time to time, your insurance may request additional information in order to provide reimbursement. This may include (but is not limited to) chart notes, x-rays, reports, and correspondence relating to treatment in our office. By seeking treatment from Fisher Chiropractic, and authorizing this clinic to bill my insurance on my behalf, I release the above mentioned information as it pertains to payment from my insurance company for the treatment I receive.
Patient Initial: _____

If you have secondary or supplemental insurance, you will be responsible for all billings to that insurance company. We will be happy to provide you with a print out to submit to insurance.

Private Pay: We expect payment in full at the time of each visit, for which you will receive a wellness charge. We cannot offer our wellness charge if payment in full is not made at the time of the visit.

Workers' Compensation: Chiropractic coverage is limited to 18 visits or 60 days from the date of your first chiropractic visit, whichever comes first. After that time, if care is still required, other arrangements will be made. We will bill your workers' compensation carrier and collect payment directly from them. In the event that your claim is denied, you will be responsible for payment in full.

Please make sure you have filed an accident form #801 with your employer.

Auto Insurance: Our office will check your policy for the conditions of your chiropractic coverage. If your insurance company agrees to pay the bills, we will bill them and collect payment. If the other driver's insurance is responsible or if no one accepts responsibility, you may be asked to pay for each treatment at the time of the visit. In any case, you are ultimately responsible for payment.

Medicare: Dr. Fisher does not accept assignment on Medicare. Therefore, we will bill Medicare for you and charge you what Medicare would pay. We expect payment from you at the time of each visit, and for any services not covered by Medicare, accepted service charges up to the deductible amount or the patient portion of the accepted charges. (It may be necessary to estimate these amounts). Medicare will not pay for exams, x-rays, physical therapy, nutrition, or orthopedic supports. Also, Medicare does not pay for treatment to upper or lower extremities. We may not ask you to pay the patient portion if there is an automatic supplemental insurance that will pay us directly. Please ask the receptionist if you have any questions regarding Medicare procedures and policies.

Financial Hardship: We expect payment at the time of each visit. If for any reason you are unable to comply with is request, please speak with the doctor and/or office manager and we will make every effort to arrange a suitable financial agreement.

Massage: Payments for massage is expected at the time of service. If you cancel or fail to report for a massage with less than 24 hour notice, you will be responsible for the full price of the massage. We do not bill insurance companies for missed massages.

I HAVE READ THIS PAYMENT POLICY AND UNDERSTAND THAT, REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE, I AM RESPONDSIBLE FOR PAYMENT OF MY ACCOUNT WITHIN THE USUAL LIMITS OF THIS POLICY. I AGREE THAT IN THE EVENT THAT COST AND/OR FEES ARE INCURRED IN CONNECTION WITH THE COLLECTION OF MY ACCOUNT, I WILL PAY ALL SUCH COSTS AND FEES INCLUDING COLLECTIONS COST, ATTORNEYS FEES AND COURT COSTS.

_____ Date_____

Patient Signature

_____ Date_____

Responsible Party if other than Patient