ActiveLife Chiropractic
Dr. Jocelyn Kirnak, D.C.
5201 SW Westgate Drive Suite 119 Portland, OR 97221 | P: 503-335-0449

Confidential Patient Registration

Name:_____DOB;_____Date:_____

Email:_____Phone:_____

Cell Phone:_____Work Phone_____

Sex: M__ F__ Marital Status: M__S__W__D__Minor__ Been to Chiropractor before?_____

Home Address: _____

City: _____ State: _____ Zip: _____

Who can we thank for referring you to our clinic? _____

Emergency Contact;_____Phone_____Relation_____

Confidential communication preference (x-ray reports, appt. confirmations):_____

Employer:_____City:_____Occupation:_____

INSURANCE INFORMATION : Company:_____HSA? Y/N

Policy ID#___ _____Group #:_____

Are you main policy holder? Yes/No **If NOT,** what is the name/date of birth of policy holder?

Name:_____DOB:____/____/____Relation:_____

Insured's Employer: _____

INSURANCE INFORMATION (SECONDARY, IF APPLICABLE):

Company: _____ Name of Insured: _____

D.O.B.: _____ Relationship to Insured if other than self: _____

I.D. Number: _____Group Number: _____

Is your condition due to an injury/illness that occurred at your place of work: yes/no

Is your condition due to an injury/illness that occurred due to an auto accident? yes/no

If you answer YES to either of the above questions, you MUST complete the correlating intake form for your case. Please alert the front office staff. Thank you.

What operations have you had?_____

Serious illnesses:_____

Patient Name_____DOB_____Date_____

List all medications currently taking:_____

_____

Supplements/vitamins:_____

Primary Care Physician_____Females, are you pregnant?_____

INSURANCE:

As a courtesy, this office will check your coverage and benefits, and will process your insurance forms.

INSURANCE PATIENTS: "I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorize the release any information that is necessary to process this claim and and assign all chiropractic benefits, including major medical benefits to which I am entitled, to ActiveLife Chiropractic/Dr. Jocelyn Kirnak, D.C. " Initial_____

"Should collection procedures become necessary to collect the amount due to this clinic, for my treatment, additional charges for attorneys' fees and interest will be added to the balance owed for my treatment. I understand that such payment is not contingent on any settlement or insurance payment." Initial_____

"I authorize release of patient's records to third parties requiring these records for determination of financial liability." Initial_____

I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at ActiveLife Chiropractic." Initial_____

By signing this application I affirm under penalty that I have given true complete information.

Dated this _____ day of _____ 20_____.

Patient Signature_____Guarantor's Signature_____

Guarantor's Relationship to Patient_____

AUTHORIZATION TO TREAT A MINOR;

By signing below, I acknowledge and represent that I am the parent or legal guardian of:

_____ Date of birth_____

I hereby authorize any chiropractic, physiotherapy, or massage therapy treatments deemed advisable at this time as well as at the time of any future visits deemed necessary for this patient if a parent or legal guardian is not available when the child is brought in for treatment. This authorization will be effective as of __/__/_____.

Parent/Guardian Signature:_____Witnessed by:_____

Patient Name_____DOB_____ Date_____

HEALTH HISTORY:

Please list reasons for seeking care:

_____

_____

_____

How often are the complaints present? Constant (76-100%) Frequent (51-75%)
Occasional (26-50%) Intermittent (25% or less)

How bad is your pain? Circle one: 0 1 2 3 4 5 6 7 8 9 10 (**10= screaming out loud** pain). If your pain varies from day to day, please circle two numbers

Since your problem began is it: Increasing decreasing not changing

When did your problem begin? (specific date if possible)_____

Describe how your problem began (do you know what caused it?):_____
_____

What treatment have you received for this condition?_____

Were you previously treated for a different occurrence of the same condition? Yes or No. If yes by: MD, DC, LMT, PT, Other_____ Names of Providers:_____

_____

What makes your problem better? _____

What makes the problem worse? _____

Any other areas of concern?_____

How would you grade your general stress level? No stress,; Minimal stress; Moderate stress; Greatly stressed

General physical activity: No regular exercise Light exercise strenuous exercise

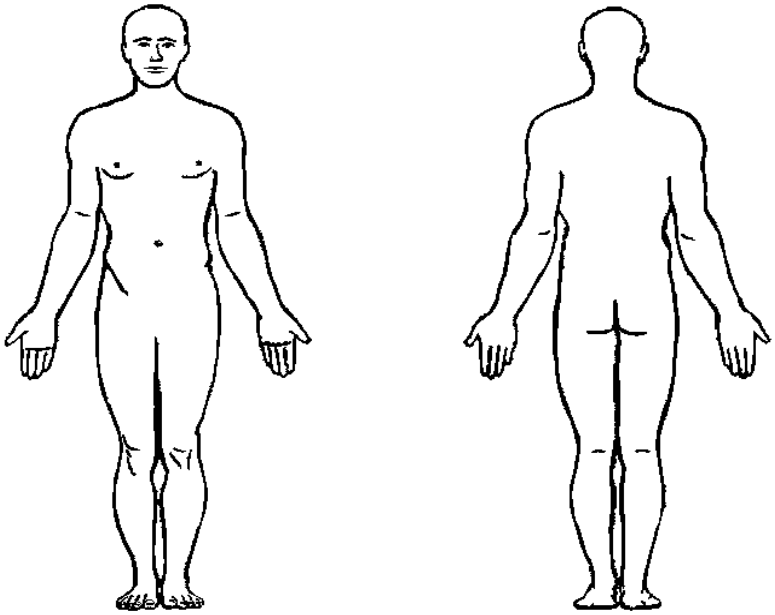
Are your complaints affecting your ability to work or sleep or otherwise be active? _____

Have you been diagnosed with venereal disease? Yes or No Have you been diagnosed with hepatitis C? Yes or No

Have you tested HIV positive? Yes or No

Patient Name_____DOB_____Date_____

MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



FAMILY HISTORY

Do/did your Mother, or Father have any of the following: **M** = Mother **F** = Father

( ) High Blood Pressure ( ) Heart Attack ( ) Diabetes ( ) Cancer

( ) Seizures ( ) Ulcer or Stomach Problems ( ) Stroke ( ) Mental Illness

PERSONAL HABITS

Do you smoke? Yes or No Cigarettes: _____ packs per day (used to smoke _____ packs/ day)

Alcohol? Yes or No Amount and frequency_____

Sugar intake amount: High Moderate Low Very Low

Number of hours of sleep per night?_____ Is it restful sleep?_____

Number of cups of (circle one) coffee tea soft drinks per day_____

Present weight: _____ Height: _____ feet _____inches

What type/frequency of exercise? _____

_____

Patient Name_____DOB_____Date_____

PAST AND PRESENT MEDICAL HISTORY:

Dizziness/vertigo? Y/N Lightheadednes/fainting? Y/N

Double or blurry vision? Y/N Difficulty with speech? Y/N

Difficulty swallowing? Y/N Indigestion? Y/N

Nausea/vomiting? Y/N Loss of balance/coordination? Y/N

Numbness on 1 side of your face/body? Y/N Headaches for hours or days? Y/N

Numbness/tingling in hands or feet? Y/N Chest pain? Y/N

Change in bowel/bladder habits? Y/N Unusual bleeding/discharge? Y/N

Nagging cough or hoarseness? Y/N Jaw pain or clicking? Y/N

Drooping eyelid or change in pupils? Y/N Night sweats? Y/N

Swelling of ankles? Y/N Low/high (circle) blood pressure? Y/N

Fever? Y/N Nervousness/depression? Y/N Pacemaker? Y/N

Frequent urination? Y/N Bleeding or discharge? Y/N

Bed-wetting? Y/N Ringing in the ears? Y/N Artificial joints/breast implants? Y/N

Are you losing/gaining weight now without trying? Y/N A sore that doesn't heal? Y/N

Diarrhea or constipation? Y/N Allergies/Asthma? Y/N

Anemia? Y/N Diabetes/Pre-diabetes? Y/N Scoliosis? Y/N

Excema/Psoriasis? Y/N Heart disease? Y/N Herpes? Y/N

Other diseases/conditions? _____

Questions? _____

Signature_____Date_____

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CLINIC FINANCIAL POLICY

PAYMENT RESPONSIBILITY: You will be expected to pay any estimated co-pays, **co-insurance, and/or deductible amounts**, as well as for any supplies **at the time of service**, unless other arrangements are made. We accept cash, checks, H.S.A. or flex cards, or Visa/Mastercard. There is a bounced check fee of **$30.00**. Dr. Kirnak is a preferred provider with most private insurances, including Aetna, Blue Cross, Cigna, Moda Health, Providence and others.

We will gladly submit your medical bills to your insurance. You will be balance billed any remaining charges after your insurance processes your claim. You are responsible for timely payment of your account. **Patient balances are due 30 days after receipt of your statement**. Balances over 60 days are subject to a $20 statement re-billing fee. Balances 90 days past due may be reviewed for collections, and if sent to collections, a fee of 35% of the overdue amount may be assessed.

We ask that patients give **48**-hours' notice for cancellations or rescheduling, **There wil be a $35 fee charged for missed appointments not cancelled or rescheduled at least 24 hours in advance, for which the patient is responsible regardless of insurance coverage.**

TIME OF SERVICE (Self-pay) Payments
ActiveLife strives to provide excellent , individualized care that is reasonable and necessary for our patients at an affordable price. For those that do not have insurance coverage or do not with to utilize existing coverage, you must sign the **Self-Pay Patient Agreement form**. If at any time you present insurance to our clinic to bill on your behalf within your insurance company's timely filing and policy guidelines, we will commence submitting claims to your insurance company. Under some circumstances, payment plans or financial hardship rates may be available for Self-Pay patients.

MEDICARE NON-COVERED SERVICES:
According to Medicare law, many of the services in our office are NON-COVERED and are the responsibility of the patient. We know this can be confusing, so please feel free to talk to Christine or Dr. Kirnak before your visit/exam. Our goal is to make your experience here as user-friendly as possible!

Patient_____DOB_____Date_____

Examples of Non-Covered Services by Medicare:

All Services other than Chiropractic Spinal Adjustments: office visits to evaluate and manage, re-evaluate, advise, or give counsel regarding your health; physiotherapy such as massage, ultrasound, microscurrent, therapeutic exercises, trigger point therapy, and vitamins are not covered.

Various Chiropractic adjustments or Treatments: non-spinal manipulation to the foot, leg, shoulder, etc.; maintenance care of a condition which is stable and not making any more improvement.

your charges will be (due at time of service).

Self-Pay Patient agreement (for Patients choosing NOT to use their insurance benefits); Treatment: Chiropractic and/or Massage Therapy

'I understand that I am agreing to pay for my care in full at the time of service for my treatment at ActiveLife Chiropractic. By signing below, I am indicating that I have no health insurance that ActiveLife Chiropractic can bill, or I am choosing not to have my insurance billed for the services I am receiving.

Name:_____Signature_____Date_____

H.I.P.P.A. Notice: The notes that are taken during appointments are kept in your chart and are secured in our clinic at all times. Access to this office is limited to practitioners, employees, and supervised guests. Should we see you socially, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. Your confidential healthcare information is private and cannot be coped and shared with anyone else without your written, signed consent. Copies of released records are sent by mail or fax and are accompanied by a Confidential Patient Information cover sheet if faxed. Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university or healthcare clearing house in the normal course of the business, and 2) relates to the past, present, or future physical or mental or condition of an individual, the provisions of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual.

"I have read and understand the fees policies as well as my right to privacy, as stated above, and agree to have the practitioners and employees of ActiveLife Chiropractic maintain my records confidentially in accordance with the law. I agree to inform the practitioner and/ or the employees of ActiveLife if I need any special arrangements pertaining to this issue."

Name_____Signed_____