JOURNEY
CHIROPRACTIC CLINIC

Dr. Cassandra Hoy, DC
8835 SW Canyon Ln, Suite 302, Portland, OR 97225
Ph: 971-238-9464 F: 503-549-5637
Email: journeychiropracticpdx@gmail.com
www.journeychiropracticpdx.com

Patient Intake Information

Name: _____ Today's Date: _____

Social Security Number: _____ Birth Date: ____/____/____ Age: _____

Gender: _____ Pronouns: _____

Current Address

Street _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Occupation: _____ Employer: _____

Marital Status: ▢ Married ▢ Separated ▢ Widowed ▢Single # of Children: _____

Name of Spouse: _____ Spouse's DOB: _____

Spouse's Occupation: _____ Spouse's Employer: _____

Spouse's Phone Number: _____

Who should we contact in the event of an emergency? _____

Phone: _____

Address of Contact Person: _____

How did you learn about us? ▢ Referral from _____ ▢ Search Engine ▢ Website ▢ Social Media ▢ Walk-In/Drive-By ▢ Other _____

If you are under 18 years of age, who are your legal parents or guardians?

Relation/Name: _____ Phone: _____

Relation/Name: _____ Phone: _____

Relation/Name: _____ Phone: _____

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Name: _____ Today's Date: _____

Did the condition or injury result from an ***automobile accident***? ▢ YES ▢ NO

Did the condition or injury result from a ***work-related accident*** or ***cause***? ▢ YES ▢No (briefly describe) _____

If the condition did NOT result from an automobile accident or work related injury, where did the accident occur? _____

Approximately when did your injury or condition occur? ____/____/____

Describe your condition, symptoms, or reason for visiting us today: _____

_____

Have you ever had the same or similar condition? ▢ YES ▢ NO If yes, when and describe:

_____

Please indicate any other healthcare providers who you've seen for THIS injury or condition, and when you last saw them.

Name _____ Specialty _____Date _____

Name _____ Specialty _____Date _____

Name _____ Specialty _____Date _____

Date of last physical examination: _____

Please list any past hospitalizations or surgeries:

Event: _____ Year _____

Event: _____ Year _____

Event: _____ Year _____

Please list any serious illnesses or conditions:

Type: _____ Year:_____ Type: _____ Year:_____

Type: _____ Year:_____ Type: _____ Year:_____

Have you been treated for any health condition by a physician in the last year? ▢ YES ▢ NO

Describe _____

Please list any medications, drugs or supplements you are currently taking: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Have you ever suffered from: ▢ Dizziness ▢ Back pain ▢ Heart Trouble ▢ Asthma ▢ Cancer ▢ Arthritis ▢ Headaches ▢ Neck Pain ▢ Numbness ▢ Anemia ▢ Digestive Disorders ▢ Nervousness ▢Sinus Trouble ▢ Herniated Disc ▢ Loss of strength in arms/legs ▢ Shortness of Breath ▢ Diabetes ▢Neuritis ▢ Other: _____

Are you pregnant or is there any possibility you may be pregnant? ▢ YES ▢ No ▢ Uncertain

Do you have health insurance? ▢ YES ▢ No Company: _____

Insurance ID Number: _____ Group Number: _____

Full Name of Policy Holder: _____ Policy Holder's DOB: _____

Does the policy holder have insurance through their employer? ▢ YES ▢ No If yes, who is the employer? _____

****

The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ____/____/____

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HIPAA

Acknowledgement of receipt of Notice of Privacy Practice Regarding the Use & Disclosure of Protected Health Information (Consent Form)

For the purposes of this Consent Form, "Office" shall refer to: **Journey Chiropractic**.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices". I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such a copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

I have also given authorization to

_____

(Person's name and relationship to patient)

to access information on my account.

Patient Name (please print):

_____

Signature: _____ Date: ____/____/____

If patient is a minor

_____ Date: ____/____/____

Signature of Patient Representative
(Required if patient is a minor or adult unable to sign this form)

Relationship to Patient: _____

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Financial Agreement

Please remember that insurance is considered a method to reimburse the patient for fees put to the doctor and it is NOT A SUBSTITUTION FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balances not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.
If this account is assigned to an attorney/outside agency for collections and/or suit, Journey Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

Patient Signature Date

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Journey Chiropractic all medical benefits and/or insurance reimbursement. If any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan, any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to any medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with doctor and clinic against such insurers and/or employee healthcare plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature (Insured or Guardian) _____ Date _____

Print Name _____

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Authorization to Disclose Medical Records

Patient Name: _____ Patient DOB: _____

Information to be released from:

Name of facility and/or provider: _____

City: _____ State: ____ Phone: _____ Fax: _____

Information to be sent to: Journey Chiropractic
8835 SW Canyon Ln, Suite 302, Portland, OR 97225
P: 971-238-9464 F: 503-549-5637

Purpose of disclosure:

The information will be used on my behalf for the following purpose: _____

Information to be released:

By initialing spaces below, I specifically authorize the release of the following medical records, if such records exist.

___Medicar records needed for continuity of care ___Most recent 5 year history

___Laboratory Reports ___Clinician office chart notes

___ Pathology Reports ___Physical therapy records

___ Diagnostic Imaging ___Billing records and statements

___ Other (please specify)

___Please send the entire medical record (all information) to the above named recipient.

Recipient understands this record may be voluminous and agrees to pay reasonable charges associated with providing records.

___ HIV/ AIDs related records ___Genetic Testing Information

___ Mental Health Information ___Drug/Alcohol diagnosis, treatment, and referral.

*** Must be initialed to be included in other documents**

Federal Regulation 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

___ This authorization is limited to the following treatment: _____

___ This authorization is limited to the following period: _____

___ This authorization is limited to a worker's compensation claim for injuries of _____

I understand that I may refuse to sign this authorization and that my refusal to sing will not affect my ability to obtain treatment, payment, or my eligibility benefits.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____

Patient Signature Person Authorized by Law Signature

Date:_____ Date:_____