Welcome to
Oregon Coast Chiropractic

1.ABOUT YOU

Date:_____
Full Name:_____
What you prefer to be called:_____
DOB:_____
Mailing Address:_____
_____
Preferred Phone Number:_____
Alternate Phone Number:_____
E-Mail Address:_____
How did you hear about this office?
_____
Occupation and Employer: _____
_____
Do you have children?_____ How many? ____

2.REASON FOR VISIT

Complaint is result of (please **circle**):
work, sports, auto accident, trauma, chronic

Briefly describe what happened:_____
_____
_____

Please describe pain and its location: _____
_____
_____
_____

When did this begin?_____
Has this happened before?_____
What other treatments have you tried?_____
_____
Have you ever been treated by a chiropractor?
_____

3. HEALTH HISTORY

Please **circle** any conditions you have ever had:

High blood pressure	Headache
Jaw Pain	Cancer
Asthma	Heart Problems
Seizures	Shingles
Kidney Problems	Artificial Joints
Sinus Problems	Diabetes
Alcohol/Drug Problems	Psychiatric Problems

Other: _____

Please list any past serious accidents/injuries:
_____
_____
_____

Please list any past surgeries or procedures:
_____
_____
_____

Please list current medications: _____
_____
_____

Family Health History: _____
_____

Do you smoke? _____ How long? _____
Do you exercise?_____ What type? _____

4. EMERGENCY CONTACT

Name_____
Phone #_____
Relation_____
Optional:
Primary Care Provider: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date:_____

INFORMED CONSENT

The word "*chiropractic*" is derived from the Greek words "*chiro*", meaning "hand" and "*praxis*", meaning "practice"; so chiropractic is literally healthcare *performed by hand*. As a patient at Oregon Coast Chiropractic, you should expect to be touched, moved, assisted, and adjusted by Dr. Olejnik. Occasionally, complications may arise from the care rendered. **The purpose of this consent form is to inform you of the possibility of complications or adverse effects.** Please read, initial, and sign the following consents to examination and treatment, permitting us to continue.

Chiropractic examination procedures include, but are not limited to, your health history, posture and range of motion evaluation, orthopedic and neurological testing, palpation of various body structures, spinal and extremity mobilization, manual or mechanical muscle testing and palpation, and referral for specialized testing such as blood evaluations, diagnostic imaging, and other tests.

Chiropractic therapeutic procedures include, but are not limited to, spinal and extremity manipulation/mobilization, manual or mechanical muscle therapy, exercise demonstration and prescription, physiotherapy applications such as ice, heat, ultrasound, and electrotherapy, referrals to other practitioners, nutritional recommendations, and advice on posture and homebased self-care. The most common adverse effects of chiropractic treatment are short-term soreness and/or a temporary increase in pain. **The likelihood of initial soreness or increased pain has been found to be similar to that of starting an exercise program[1].** In fact, a systematic review of the literature indicated **that most adverse events that could be attributed to spinal manipulation were benign and transitory[2].**

Fractures are rare and usually the result of an underlying bone pathology that we will try to assess during your history and examination. An event sometimes attributed to chiropractic manipulation is a stroke resulting from a cervical artery dissection[3]. This event is very rare, occurring at a frequency of between one per million and one per five million visits to a chiropractic office. **To date, no study has shown a causal relationship between cervical spine manipulation and stroke.** Research has demonstrated that a patient is as likely to have seen a primary care medical doctor as a doctor of chiropractic prior to experiencing a cervical arterial dissection[4]. In other words, the association of strokes and visits to either chiropractors or primary care physicians was equal, suggesting that the cause of the strokes could not be associated with any element unique to chiropractic care.

Naturally, Dr. Olejnik will discuss our treatment plan with you. She will also inform you of other options for care, to the best of her knowledge. Please note that all forms of healthcare include some form of risk. In fact, there are even risks to not receiving care that may include a worsening of your current complaint or development of other untoward complications.

Please read the above before signing this consent. If you have further questions or desire more information, simply ask Dr. Olejnik.

Upon signing this form, I affirm that I have read and understand the above statements regarding treatment-related adverse events. I also understand that there is no guarantee or warranty for a specific cure or result. I consent to examination and treatment.

Patient Name (printed):_____

Signature:_____

Date: _____

References:
1 Bronfort et al., 2001; Hurwitz, Moregenstern, Vassilaki, & Chiang, 2005
2 Gouvela, Castanho, & Ferreira, 2009
3 Rothwell, Bondy, & Williams, 2001; Smith et al., 2003
4 Cassidy, et al, 2008

FINANCIAL POLICY

Dr. Olejnik's goal is to make your visits as smooth and efficient, as well as financially feasible and an excellent value. She will work to provide thorough, effective care to help you feel better in as few visits as possible. She does not participate with any insurance panels (is "out-of-network" with all insurance companies). This is in order that all treatment and cost decisions can be made directly between patient and provider, without any intermediaries.

As a small practice, and to help keep costs reasonable, Dr. Olejnik does not verify insurance benefits or bill private insurance carriers or Medicare. It is recommended that patients call their insurance companies to determine if they have out-of-network chiropractic benefits and what forms or procedures are necessary in order to receive reimbursement. Most patients will pay for treatment out-of-pocket, but documentation (such as Superbills) will gladly be provided for those who intend to seek reimbursement from insurance.

The financial policy of Oregon Coast Chiropractic states that all services provided must be paid in full within 30 days of service. Patients may pay via check or credit card at the time of service. You may also wait to receive an invoice via email or mail and pay accordingly via credit card online or by check in the mail. A $25 fee may apply to late payments.

A $25 fee will be charged for all missed appointments or cancellations with less than 24 hours' notice, unless there is an emergency reason. Please call or make schedule changes online 24 hours prior to your appointment if you cannot make your scheduled time to avoid the charge. We cannot bill any insurance for this fee.

In the event you are treated for a motor vehicle or a worker's compensation injury, the appropriate carriers can be billed after you provide all necessary billing information. This is done due to the temporary nature of such claims and as a service to patients under duress in these situations.

Please understand that this office cannot accept responsibility for collecting your motor vehicle or worker's compensation insurance claim or negotiating a settlement on a disputed claim. The ultimate responsibility for payment for services is with you. If you have questions regarding your benefits or coverage, please call your insurance company.

Special arrangements may be made for patients needing financial assistance. Dr. Olejnik understand that financial problems arise from time to time. If you need to arrange a payment plan please let her know so she can assist you in arranging a plan that will allow you to receive (or continue) your treatment. Please feel free to ask if you have any questions regarding this policy.

I have read, understand and agree to this Financial Policy.

x_____ _____

Signature of Responsible Party Date

_____

Please print name

NOTICE OF PRIVACY PRACTICES

Keep this page for your records

Oregon Coast Chiropractic is very concerned with protecting your privacy. While the law requires that you receive this disclosure, please understand that the privacy of your personal health information (PHI) is, has been, and always will be respected. In accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we are providing you with a written notice of our privacy practices for your records. We are obligated to notify you promptly if any breach occurs that may have compromised the security of your PHI. We are also required by law to abide by all terms in this notice.

There are several circumstances in which your health care information may have to be used or disclosed without your express consent:

For Treatment: Your health information may been to be disclosed to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

For Payment: Your health information and billing records may be disclosed to another party if they are potentially responsible for the payment of your services.

For Health Care Operations: Your health information may be used within this practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news.

Use or disclose your PHI for marketing purposes or for sale to third parties specifically requires your written permission and will never be done without it.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions other use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to inspect, copy, and amend your PHI. Submit your request in writing and specify what type of information is desired and the reason (if requesting amendment). You may be charged for the cost of copying, mailing, or other expenses associated with your request.

Consent to send correspondence of Medical Records over email with the understanding that the email is not encrypted. Although we have taken precaution to utilize a designated server for email correspondence, it does not fully meet all the HIPAA security requirements. By signing below, you also understand the potential risk of sending medical records from your email to our server and the potential risk of information possibly leaking to a third party.

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record

Oregon Coast Chiropractic is committed to protecting my privacy and personal health information (PHI).

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on behalf of Oregon Coast Chiropractic. A copy of this document was made available to me for my records.

I understand that the Notice describes the uses and disclosures of my protected health information by Oregon Coast Chiropractic and informs me of my rights with respect to my protected health information.

_____

Patient's Signature (or that of Legal Representative

_____

Printed Name of Patient (or Legal Representative)

_____

Date