

Phillip Snell, D.C.
Chiropractic Physician

Scott Haines, D.C.
Chiropractic Physician

Cory Peterson, D.C.
Chiropractic Physician

Taya Lindley, L.Ac.
Licensed Acupuncturist

Eva Hosseinion, L.Ac.
Licensed Acupuncturist

Kelly Owens, ND
Naturopathic Doctor

Aimee Perkins, LMT
Therapeutic Massage

Sara Armstrong, LMT
Therapeutic Massage

Sheri Blue, LCSW, CADC I, LMT
Counseling, Therapeutic Massage

Hawthorne Wellness Center

3942 SE Hawthorne Blvd. • Portland, OR 97214 • (503) 235-5484

The following information is needed for our files so we can better serve you as a patient. Please fill in ALL portions of the form.
PLEASE PRINT CLEARLY. Thank you.

Patient Information

Patient's Name: _____ Nickname: _____ Date: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ E-MAIL: _____

Employer: _____ Work #: _____ Occupation: _____

Age: _____ Date of Birth: _____ Gender: _____ Marital Status (Circle One): S P M D W

Referred to this clinic by: _____

Number of Children & Ages: _____

THIS PATIENT IS A MINOR. PERMISSION IS HEREBY GIVEN BY ME TO THE PROVIDERS OF THIS CLINIC TO EXAMINE AND TREAT THE PATIENT.

Signature: _____ Printed Name: _____ Date: _____

Insurance Information

Who are we billing? Self Pay/Not Billing Insurance Auto Insurance Workers' Compensation Personal Insurance

Primary Insurance Company Name: _____ Phone # (back of card): _____

Policy/ID #/Claim #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

I give my consent for Hawthorne Wellness Center to contact the above named person in case of an emergency.

Signature: _____ Date: _____

Appointment Reminders

Please choose **ONE** of the following options: Voice Message E-Mail Text Message No Reminder

Taya Lindley, L.Ac.
Licensed Acupuncturist

Eva Hosseinion, L.Ac.
Licensed Acupuncturist

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Name: _____ Date of Birth: _____ Date: _____

Primary reason for today's visit: _____

Have you received treatment for this condition? _____ If yes, by whom? _____

What was the diagnosis? _____ How long have you had this condition? _____

Do you know what caused it? _____

What have you done to treat the problem? _____

To what extent does it interfere with your daily life? _____

Are you taking any medications? _____ If yes, please list: _____

Supplements? _____ If yes, please list: _____

Do you consider your health to be: Excellent Good Fair Poor

Do you have any chronic infectious disease? Yes No If Yes, explain: _____

Are you currently suffering from any chronic illness? Yes No If Yes, explain: _____

Please list any foods, drugs, medications or herbs that you are hypersensitive or allergic to (please include type of reaction):

Please list any surgeries and date: _____

Height: _____ Weight: _____ Past Maximum Weight: _____ When? _____

Are you happy with your current weight? _____ If no, please explain: _____

Blood Pressure: What is your most current blood pressure reading? _____ / _____ Date: _____

Family History: Cancer Diabetes Heart Disease HTN Stroke Mental Illness

For the following please circle any symptoms that you experience now and underline any symptoms that you have experienced in the past:

Musculoskeletal: Neck/Shoulder Pain Muscle Spasms/Cramps Muscle Weakness Arm Pain Back Pain Leg Pain
Broken Bones Joint Pain (where?) _____

Emotional: Mood Swings Nervousness Mental Tension Anxiety Depression

Energy and Immunity: Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose and Throat: Impaired Vision Glasses/Contacts Tearing/Dryness Eye Pain/Strain Glaucoma
Impaired Hearing Ringing in Ears Ear Aches Frequent Sore Throats Hay Fever/Allergies Nose Bleeds

Sinus Problems Headaches Head Injury Teeth Grinding TMJ Lip or Mouth Sores Gum Problems

Respiratory: Difficulty Breathing Frequent Common Colds Persistent Cough Pneumonia Bronchitis Emphysema
Pleurisy Asthma Tuberculosis

Endocrine: Hyper or Hypo thyroid Diabetes Feeling Hot or Cold Night Sweats

Cardiovascular: Heart Disease Chest Pain Shortness of Breath Palpitations/Fluttering Heart Murmur HTN
Stroke Fainting Ankle Swelling Varicose Veins

Gastrointestinal: Trouble Swallowing Nausea/Vomiting Heartburn Change in Appetite Change in Thirst Bloating
Belching or Passing Gas Abdominal Pain Constipation Diarrhea Undigested Food Mucous or Blood in Stool
Hemorrhoids Gall Bladder Disease Liver Disease Hepatitis B or C

Neurological: Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Female Reproductive/Breasts: Irregular Cycles Breast Lumps/Tenderness Heavy Flow Bleeding Between Cycle
Vaginal Discharge Clotting Painful Menses PMS Menopausal Symptoms Difficulty Conceiving STD
Painful Intercourse Sexual Difficulties

Last menstrual period: _____

Male Reproductive: Sexual Difficulties Prostate Problems Testicular Pain/Swelling

Other: Anemia Cancer Rashes Eczema/Hive Cold Hands/Feet Headaches

Lifestyle:

Please indicate typical food intake:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you feel that you have healthy eating habits?

Consumption of liquids (ie. water, soda):

Nicotine/Alcohol/Caffeine use:

Daily Exercise:

Sleep Habits:

Education:

Occupation:

Employer:

Hours/Week:

Do you enjoy work?

Why/Why not?

Have you experienced any major traumas? Y N Explain:

Television Habits:

Interests and Hobbies:

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____ Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** _____ (Date)
(Or Patient Representative) _____ (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** _____ (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

FINANCIAL POLICY AND AGREEMENT

Cancellation & Missed Appointment Fees

A 24-hour notice is required for appointment cancellations. If we do not receive a 24-hour notice, you will be charged a \$60 appointment cancellation fee. A \$60 charge will be billed for all missed appointments.

Please **thoroughly read through the details of the method of payment that applies to you**, sign that you have read and agree to abide by the financial policy as listed below. Please also **initial** the method of payment box that pertains to you.

Self Pay/Not Billing Insurance

Payment is expected at the time services are rendered. Cash, checks and credit cards (excluding American Express) are accepted for payment. An administrative discount is offered to patients who pay their account in full at the time of service, maintain a zero balance on their account and do not require insurance billing by this office.

Auto Insurance

You must notify your insurance carrier of the accident and file a Personal Injury Protection (PIP) form with them. We will bill your auto insurance company. In the event the auto insurance check is sent to you, you are expected to bring the check to our office to be applied to your account. If for any reason your claim is denied or not paid in full by your insurance company, you will be responsible for your bill.

Workers' Compensation

You must report your injury to your employer and fill out an injury report form (801) at your place of employment. We will bill your Workers' Compensation carrier. If for any reason your claim is denied or not paid in full, you will be responsible for your bill.

Private Insurance

If you have insurance, which covers alternative care or mental health, we will bill your insurance company directly. Copays are due at the time of service. If you have a Coinsurance or Deductible, you will be billed upon receipt of the Explanation of Benefits from your insurance company. In the event the insurance check is sent to you, you are expected to bring the check to our office to be applied to your account.

- Verification of benefits is not a guarantee of payment by your insurance company.
- Any services not covered by your insurance plan are your responsibility. Services sometimes not covered by insurance may include, but are not limited to: TMJ/TMD Treatment, Fertility Treatment, Massage by a Licensed Massage Therapist.
- Some insurance plans have a separate benefit for each treatment code billed. Example: A chiropractic office visit, spinal manipulation and manual therapy codes might each have a separate benefit. Often manual therapy codes are applied to a deductible. It is YOUR responsibility to know your covered benefits.

I authorize my insurance company to make payment directly to this clinic for services rendered and permit this clinic to endorse co-issued remittances for the conveyance of credit to my account. **I understand this clinic will prepare any medical records, necessary forms and reports to assist me in making collection from my insurance company and that any amount paid directly to this clinic will be credited to my account upon receipt.** However, I clearly understand and agree that all services rendered are charged to me directly and that I am ultimately personally responsible for full payment. I agree to pay any costs or fees incurred in connection with the collection of my account, including attorney fees and court costs.

I have read, understand and agree to abide by the above financial policy that applies to me, including the Cancellation & Missed Appointment policy.

Signature: _____ Date: _____

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ACKNOWLEDGMENT AND CONSENT

I understand that **Hawthorne Wellness Center** (referred to below as "HWC") will use and disclose **health information** about me.

I understand that my **health information** may include information created and received by HWC, may be in the form of written or electronic records and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that HWC may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with cost-effective health care.

Notice of Privacy Practices describes my rights regarding my health information and the uses and disclosures of health information and the protocol followed by the providers and staff of HWC.

I understand that a copy or a summary of the most current version of HWC's Notice of Privacy Practices will be in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that HWC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above.

By: _____ Date: _____ (Patient)

-OR-

By: _____ Date: _____ (Patient Representative)
Description of Representative's Authority: _____

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Email Communication Consent Form

Your email will not be sold or shared. We will not be sending you any newsletters or advertisements. This is a HIPPA compliant form required in order to allow correspondence between you and your healthcare provider, as well as our staff and billing department, if you so choose. Here are some examples of email correspondence:

- Receive exercises from your chiropractor.
- Request supplements from your provider.
- Receive notifications from your provider upon supplement shipment arrival.
- Correspond with our billing department.
- Appointment reminders, if that is the method of reminder you have chosen.

Risks and Conditions of Using Email

I have been advised that:

- I may not use email to cancel or schedule appointments. All scheduling must happen via phone or in person due to an ever-changing scheduling calendar.
- Email is never appropriate for urgent or emergency problems.
- Emails should not be used to communicate sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, substance abuse, etc.
- All email correspondence will become a part of my health record. It is extremely important to include name and date of birth on each and every email to my healthcare provider. Since email may not be monitored while my healthcare provider is away on business or vacation, I will follow up by telephone or in person if I don't receive a response within a reasonable amount of time.
- Email is not confidential. Employers have a legal right to monitor email if they choose; system operators for most email systems have access to all email that passes through their systems.
- There is not a way to assure the privacy of email on a shared computer or email account.
- Email communications travel across the public Internet. It is not possible to verify that email is actually received, opened and read by the addressee.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email as a form of communication between Hawthorne Wellness Center and myself. I understand that I may revoke this agreement at any time by contacting Hawthorne Wellness Center in writing.

Signature: _____ Date: _____

Name (Printed): _____

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