City Fit
Family Chiropractic Center LLC

Date___________________

NEW PATIENT REGISTRATION

Name____ Date of Birth____________________
Last First Middle
Mailing Address____**
Street Apt# City State Zip
Home Phone # _____________________ Work Phone # ___________________________

Cell Phone # ____________________________ Email address ___________________________

Please indicate preferred phone contact: Home / Work / Cell

Emergency Contact_____________________Relationship _____________ Phone#__________________

We email appointment reminders and occasionally send important office information. You may opt-out of emails at any time. Your information will never be sold, shared or distributed.

Marital Status M S W D (if different than above) Spouse's name_________ Spouse's Phone#___________

Employer______________________ Occupation____

**Please notify our staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above. Your information will never be sold, shared or distributed.

The following information is collected by the National Institues of Health if you should choose to provide it:
Race: ☐White ☐Black/African American ☐Native Indian/Native Alaskan ☐Asian ☐Native Hawaiian/Pacific Islander ☐Other
Multi-Racial: ☐Yes ☐No ☐Unknown
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐I choose not to specify

How did you hear about us? *Referral* | *Mail* | *Website* | *Internet search* | *Insurance* | *Other*
If referral, who may we thank? ____

Is this visit routine/accident/illness/other: _______________ If Accident (date) _______________

Insurance and Payment Information

Do you intend to use health insurance? ☐ Yes ☐ No
Are you covered by Medicare? ☐ Yes ☐ No
Are you covered by Medicaid? ☐ Yes ☐ No

Insurance Information: Ins. Company ____
Policy holder name/Date of Birth/Relation (if different than above)_________________________
Insurance ID#___________________ Group ID#_____________________ Copay?______________________
Adjuster Name:____________________

Please note: Because we offer to bill insurance on your behalf as a courtesy, we request the above information at least 1 business day ahead of your initial appointment time. If we are not provided this information in advance, we will do our best to verify your insurance coverage at the time of your appointment, but we cannot guarantee verification. It is important that you are aware of your benefit details and understand that your insurance coverage is a contract between yourself and your insurance carrier, and you assume responsibility for any charges for services rendered in treatment at City Fit Chiropractic Center LLC.

PLEASE COMPLETE ALL PAGES

ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. ______I hereby authorize City Fit Family Chiropractic Center LLC and Lisa Jewell DC LLC and the doctors on staff to provide chiropractic and other necessary health care services for me as they deem appropriate.

2. ______I understand and agree that all services rendered to me at this office are my responsibility, regardless of insurance coverage. I have read and signed the clinic financial policy and understand that even if submitted to insurance for payment, I am ultimately personally responsible for payment.

3. ______If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. ______Email: Email is not to be used for appointment scheduling, sensitive and/or urgent matters. Reply times will depend on when email is accessed and can range from one to several days. Please be aware that office staff may not access email while on vacation. Email may entail some privacy risks and *is not HIPAA compliant*. If you choose to communicate by email, you accept this risk. Please be concise; if we cannot answer you very briefly, the matter is probably more complicated and should be addressed at the next office visit. You may use the Patient Portal (https://portal.fh-cloud.com/#/login) to securely communicate with Drs, staff, and the office.

5. ______I authorize release of my patient records to third parties requiring these records for determination of financial liability and/or for the coordination of care with other medical care providers. I can revoke this authorization by submitting a written notice to Andrea L Herrst DC, or Lisa Jewell DC c/o City Fit Family Chiropractic Center LLC, 319 SW Washington St, Suite 1001, Portland OR 97204.

6. ______I authorize release of my personal health records (including chart notes, x-rays, examination forms, et al) to Andrea L Herrst DC, Lisa Jewell DC LLC and City Fit Family Chiropractic Center LLC, for purposes of coordinating and informing my treatment while under care in this office. I can revoke this authorization by submitting a written notice to Andrea L Herrst DC, or Lisa Jewell DC LLC c/o City Fit Family Chiropractic Center LLC, 319 SW Washington St, Suite 1001, Portland OR 97204.

7. ______We do our best to streamline office protocols for efficiency, and by default policy, we email all patient statements electronically, which does not detail medical diagnoses. If you do not agree to this term, please submit in writing a request for mail statements, or please speak to us in person at the office. If you feel your privacy rights have been violated, you may file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. We will not retaliate if you file a complaint.

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

Dated this _________day of _______________ 20_____.

____
Patient Signature

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

____ DOB ______________________
Patient's full name

to any chiropractic or other appropriate treatment deemed appropriate for the above named mnor.

Signature_______________________________________Witnessed by ____________________

City Fit
Family Chiropractic Center LLC

FINANCIAL POLICY

- City Fit Family Chiropractic Center provides chiropractic and rehabilitative services for acute care, chronic care (usually covered by insurance, dependent on plan), and maintenance care (not covered by insurance).
- Our fees are comparable to the usual and customary charges made by like specialists in the area. These charges are based on cost, time and skill involved.
- Patients without insurance coverage are requested to pay their charges at the time service is provided.
- Patients with insurance coverage are responsible for that portion of the estimated charges not covered by the insurance company upon verification of claim processing by your insurance carrier.

Our Policy on Insurance

Please remember that all insurance plans in the US are intended for the purpose of acute injury or illness treatment. Routine maintenance care, or preventative care is unfortunately not built into any health insurance benefit plan. We offer to check your benefit plan for coverage and bill your insurance as a courtesy.

We will gladly discuss your treatment with you and answer any questions relating to your insurance. We will also assist you in collecting your insurance benefits, however, you must realize that:

1. Your insurance is a contract between you or your insurance beneficiary (usually a family member), your employer and the insurance company. We are not a party to that contract.
2. Not every service is a covered benefit with all insurance contracts. Some insurance companies are selective in what services they cover.
3. Services cannot be provided on the assumption that the charges will be paid by the insurance company, therefore, **the patient is responsible for the bill, regardless of insurance coverage.**
4. Many insurance plans have also begun to request clinical documents, or authorizations for treatment in order for representatives of the insurance company to determine medical necessity. Should your insurance plan determine that treatment in our office is not medically necessary, the cost for said treatment is the patient's responsibility.

Attention personal check writers: When you provide a check as payment, you authorize us to use information from the check to make a one-time electronic fund transfer from your account, or to process the payment as a check transaction. You authorize us to collect a fee, $25.00, (plus any bank fee charged to the merchant if allowed by Oregon state law) through electronic fund transfer from your account if your payment is returned unpaid. Please include the following information on your check: Drivers License #, Full Name, Street Address, Phone Numbers.

There is no interest or finance charge on current accounts. After 90 days, all accounts are subject to a Finance Charge of 1.75% of the unpaid balance (or a minimum charge of 50 cents), which is an Annual Percentage Rate (APR) of 21%.

If a payment from your insurance company results in a credit balance, a refund will be promptly sent to you.

____

Patient Signature Date

Notice of Policy on Missed or Late Cancellation of Appointments

Our office requires **24 hours notice** for cancellation/ rescheduling of all appointments. There will be a **$15.00 charge** to the patient, for which they are personally responsible, for all appointments that are missed and not canceled 24 hours or more before the scheduled appointment time. Patients are eligible for one (1) excused absence without charge every six months, starting from the month the patient begins care. Excused absences are not banked and do not roll-over. More than 3 cancellations for a patient's initial appointment will result in an outside referral.

***We work hard to maintain a prompt schedule and take pride in meeting patient appointments on time. We allow a 15-minute grace period for tardiness at chiropractic appointments, and a 7 minute grace period for massage appointments, beyond which, you must reschedule your appointment. We will refer you to another office for care if you run late on more than two occasions.**

I hereby assign to Andrea L Herrst, DC and City Fit Family Chiropractic Center LLC, the insurance benefits which are otherwise payable to me for her charges and direct that insurance payments be made directly to the office. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize assignee to release all information necessary to secure the payment.

Signature of Responsible Party:____

Date:____

PRIVACY PRACTICES
PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (5 pages) for City Fit Family Chiropractic Center LLC, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my New Patient Registration) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices statement.

____

Patient Signature   Date

INFORMED CONSENT

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include mild, local discomfort in the area adjusted for several hours to several days following an adjustment, sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I, the undersigned, hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself (or on the patient named below for whom I am legally responsible) by **Andrea L Herrst, DC; Lisa Jewell, DC;** and/or other licensed practioners who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic, chiropractic assistants and licensed massage therapists that are employed by, associated with or serve as back-up for **Andrea L Herrst, DC**, whether or not their names are listed on this form.

I understand and consent to the following procedures: examination, x-rays (if needed), neck, spine and extremity adjustments, joint mobilization, massage therapy, soft-tissue therapies, instrument assisted soft tissue therapy, electrical muscle stimulation, physical therapies, hot/cold therapies, traction and/or other procedures recommended for my condition(s).

I have had an opportunity to discuss with **Andrea L Herrst, DC or Lisa Jewell, DC** the various types of treatment, including spinal adjustments, instrument assisted soft tissue therapy, myofascial release and joint mobilization, which have been proposed to me for my condition and the purpose and objectives of these procedures. I understand that the results from the treatment are not guaranteed for my condition.

I understand and have had the opportunity to ask about risks and benefits to the proposed treatment and have been informed of other alternative types of treatment for my condition.

I have had the opportunity to read this form, understand the above statements, accept the risks mentioned and hereby consent to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

PATIENT NAME (PRINT):____________________________DATE:______________________________________

X____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

NAME: ________________________________ RELATIONSHIP:________________
Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor).
OFFICE/WITNESS SIGNATURE:______________________________________ DATE:_____________

Informed Consent

1. SERVICES: My healthcare provider has recommended functional, nutritional, and lifestyle evaluation, testing, consulting and care, including dietary supplements. I understand and am informed that products and services are not provided by medical physicians and do not include prescription of legend drugs, surgery, or other conventional allopathic medical treatments. I further understand that consultations, evaluations, supplementation, lifestyle consultation, testing, recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients pertain to the functional health/whole body concept.

2. NO GUARANTEE: I have been informed that the methods of nutritional evaluation or testing made available to me are not intended to diagnose disease from an allopathic model of medicine. Rather they are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor progress in achieving goals. I further understand that any recommendations are supportive in nature allowing the body to return to improved health. Like all other healthcare, results are not guaranteed and there is no promise to cure. Accordingly, I understand that payment(s) for services are not conditional on my response to care. Prorated fees for unused, prepaid services, however, will be refunded if I wish to cancel. No refunds will be available for any products purchased.

3. RISKS: I understand the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that may be recommended are generally considered safe, however, some nutritional supllements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I also understand that nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may interact with some legend drugs. Accordingly, I agree to consult with my prescribing physician about any legend drugs I am taking and the impact of supplements, vitamins, minerals, food grade herbs and other nutrients on such drugs. I will inform my healthcare practitioner if I experience gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, itching, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients.

4. PREGNANCY: I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the healthcare practitioner if I am or become pregnant.

5. ALTERNATIVES: I understand that the alternatives to the recommendations include doing nothing and/or seeking additional allopathic medical care.

6. QUESTIONS AND ANSWERS: I have read and fully understand this consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction, or if I do not understand any of the terms or words contained in this consent form.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND THIS FORM.

I have read and fully understand this consent. All items have been explained, I have had sufficient time to evaluate the information, and my questions have been answered. Knowing the alternatives and risks, I consent to the services.

Signature____ Date________________________

Name (printed) ____

CURRENT COMPLAINTS

Name: ___________________________ DOB: __________ Date: ___/___/_____

Where is your current pain/problem? ____
Does your pain/problem spread to another area? (circle all that apply)
Neck Mid-Back Low Back Arms Legs Shoulder Head Other_______________________________

When did you first notice your current problem? ______________________________________
What caused the problem/pain: Accident Work Related Unknown Other__________________
When did you notice it most recently? ____
Has this happened before? __________ When was the last time? __________________________
If this has happened before, how does the current episode compare? Same Not as bad Worse
If this has happened before, did you get it treated? Y / N What type of treatment?________________

Does it disturb your sleep? Y / N Difficult to fall asleep Wakes me up
Are your symptoms: Constant Come and go Variable with movement (circle all that apply)
Is there a time in the day when symptoms are the worst? AM Middle of the Day PM Other______

Please describe the quality of your pain/problem (circle all that apply)
Sharp Dull Tingling Achy Numb Stabbing Burning Other ___________________________________

What makes it better? ____
What makes it worse? ____
Are you taking any medications for this pain/problem? Please list_________________________________

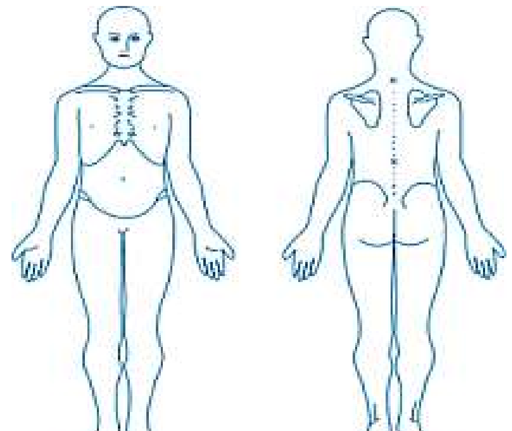
What is your CURRENT pain severity?
(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

What is your pain on AVERAGE?
(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

What is your pain at its WORST?
(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Please mark areas of your current complaint on the chart to the right, using the key below. Please indicate your Primary Complaint with the number 1

ACHE >>> Burning XXX
STABBING /// PINS AND NEEDLES 000
NUMBNESS = = = THROBBING]]]



Describe current chief complaint:____
____

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? ________ Name of office/Dr? ________________
For what reason?

Have you seen a massage therapist before? ☐ Yes ☐ No If yes, how long ago? ________ Name of therapist ____________
For what reason? What depth of soft tissue work do you prefer?_________________

Are you currently in care with another physician/practioner? ☐ Yes ☐ No If yes, for what reason?
Dr. Name and Phone #____

City Fit Family Chiropractic Center LLC | 319 SW Washington St, Ste 1001, Portland OR 97204 | 503-224-5010

Personal Health History

Patient's Name ____ **DOB** ________________ **Date** _________________

All information will be kept strictly confidential. Your responses will help determine if treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. To be responsible for your case, we need your complete health history.

Please mark conditions or symptoms that you have experienced commonly in the past or that you currently have.

Muscle / Joint

- ☐ Arthritis
- ☐ Bursitis
- ☐ Neck pain, stiffness
- ☐ Upper back pain, stiffness
- ☐ Pain between shoulders
- ☐ Low back pain, stiffness
- ☐ Painful tailbone
- ☐ Poor posture
- ☐ Spinal curvature
- ☐ Swollen joints

Pain (P) or numbness (N) in

- ☐ Shoulders R | L
- ☐ Arms R | L
- ☐ Elbows R | L
- ☐ Hand R | L
- ☐ Fingers R | L
- ☐ Hips R | L
- ☐ Legs R | L
- ☐ Knees R | L
- ☐ Feet R | L

General

- ☐ Allergy ____________________
- ☐ Asthma
- ☐ Chills
- ☐ Convulsions
- ☐ Dizziness
- ☐ Earache / Ear noise
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Hernia
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nausea
- ☐ Nervousness, depression, anxiety
- ☐ Nerve pain
- ☐ Numbness
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Sweats
- ☐ Tremors
- ☐ Weight gain

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heartbeat

Genitourinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Get up to urinate during the night; If yes, # of times______
- ☐ Excess menstrual flow
- ☐ Irregular cycle
- ☐ Painful menstruation
- ☐ Vaginal discharge
- ☐ Burning discharge from penis
- ☐ Force of urination decreased
- ☐ Kidney or bladder infections within the last 12 months?
- ☐ Problems emptying bladder completely
- ☐ Difficulty with erection or ejaculation
- ☐ Testicle pain or swelling

Gastrointestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Hemorrhoids

Skin

- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergy
- ☐ Itching
- ☐ Rash / Sores / Boils
- ☐ Varicose/spider veins

Respiratory

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

Female complaints

- ☐ Changes in skin
- ☐ Congested breasts
- ☐ Excess cramps
- ☐ Excess body hair
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause

Are you pregnant? ☐Yes ☐No
If yes, how many weeks?________
Are you trying to get pregnant?
☐Yes ☐No
If yes, for how long?_____________
Infertility treatments?_____________
# of pregnancies_________________
# of live births__________________
Are you breastfeeding?__________

Check any of the following conditions you currently have or have had :

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart disease
- ☐ Measles
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Do you have:

- ☐ Pacemaker
- ☐ Surgical implants
- ☐ Breast implants

City Fit
Family Chiropractic Center LLC

Patient's Name ____________________ **DOB** ____________ **Date** ____________

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, explain.
Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?
List all current prescription medications/over-the-counter medications/ supplements:
Height ____________ Current Weight ____________ Highest Weight / When? ____________
What is the age of your mattress? Is it ☐ comfortable? ☐ uncomfortable? Age of your pillows?
How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify) Occupation:

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	☐	☐	
- had strains or sprains?	☐	☐	
- used a cane, crutch or other support?	☐	☐	
- been struck unconscious?	☐	☐	
- had surgery?	☐	☐	
- been in an accident (car/bike/other)? When?	☐	☐	
- had a major injury or illness other than MVA?	☐	☐	

Do you:	Yes	No		Yes	No	How often?
- take minerals, herbs or vitamins?	☐	☐	-Drink alcohol?	☐	☐	
- take over-the-counter pain medications?	☐	☐	- Drink caffeinated beverages?	☐	☐	
- take any other drugs/substances?	☐	☐	-Exercise?	☐	☐	
- wear your seatbelt?	☐	☐	- Smoke tobacco of any kind?	☐	☐	Every day☐ Sometimes☐
- Vape?☐Yes ☐No ☐Every day ☐Sometimes			-Former Smoker	☐	☐	

If you are a current smoker, what is your level of interest in quitting?:

1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal or chiropractic examination?	☐	☐	☐	☐
- physical examination?	☐	☐	☐	☐
- spinal x-ray?	☐	☐	☐	☐

Please list any other health conditions you have been treated for in the last ten years.

FAMILY HEALTH HISTORY: Information about your immediate family members (brothers, sisters, parents, and grandparents) will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please mark your chief complaint areas on the figures below.

Left Right

The information supplied on this form is complete and correct to the best of my knowledge.

Patient Signature date

last updated 10/15

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www.cityfitchiro.com