2330 NW Flanders Suite 101, Portland OR 97210 (Westside)
T (503) 701-8766 F (503) 241-5484
3115 NE Sandy Blvd Suite 231, Portland, OR 97232 (Eastside)
T (503) 701-8766 F (971) 255-0727
KwanYinHealingArts.com

NEW PATIENT CHIROPRACTIC INTAKE

Legal last name _____ Legal first name _____ MI_____

Preferred Name_____

Address _____ City _____ State _____ Zip_____

Phone #_____ Work# _____ DOB _____ Age _____

Email _____ Legal Sex _____ Gender Identity _____

Pronouns _____ Relationship status _____

Employer/Occupation _____ Hours/week _____

Do you live with anyone? If so, whom? _____

Emergency contact/relationship _____ Phone# _____

Primary care physician _____ Phone# _____

How did you hear about our clinic? _____

When and where did you last receive medical/health care? _____

For what reason? _____

Insurance information

Please note that it is your responsibility to know your coverage and benefits.

Though we do not accept Medicaid, we need to know if you are covered by any Medicaid or OHP Plan Y ☐ N ☐

Insurance type: None ☐ Medical ☐ Auto Injury ☐ PIP/Personal injury ☐ Work injury/Work comp ☐

Insured's name _____ DOB _____ Patient's relationship to insured _____

Name of insurance company _____ Claims address _____

Phone# _____ ID# _____ Group# _____

Secondary (medical) insurance

Insured's name _____ DOB _____ Patient's relationship to insured _____

Name of insurance company _____ Claims address _____

Phone# _____ ID# _____ Group# _____

If Auto/PIP/Work comp injury

Date of injury _____ Claim# _____ Policy# _____

Describe how injury happened _____

Adjuster name _____ Phone# _____

Name of attorney _____ Phone# _____

Were you working at the time of the accident (or driving during work duty)? Y☐ N☐

Dates lost from work as a result of this injury _____

If auto injury, were you the: Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist ☐

Was the vehicle: Rear ended ☐ Hit from R side ☐ Hit from L side ☐ Hit head on ☐

KWAN YIN OFFICE POLICIES

Kwan-Yin Healing Arts Center, Inc. (KYHAC) welcomes you as a new patient. If you have any questions regarding our office policies, please ask any of our front desk staff for clarification prior to initialing.

Please initial each of the following:

_____**Cancellation Policy:** We require 48-hour notice for cancellations and rescheduling of appointments. If you fail to cancel 48 hours prior to the appointment, a late fee will be assessed to you (fees vary by provider), due prior to the start of your next visit. You will be personally responsible for the fee; it cannot be billed to your insurance company.

_____**Supplements:** Any and all supplements, supplies, herbs, etc. prescribed by my provider and/or purchased by me at KYHAC are my full financial responsibility with payment to be made at the time of service/purchase. KYHAC cannot bill for these items.

_____**Returned Check Policy:** KYHAC has a $35 fee for all returned checks.

_____**Patient Insurance:** Insurance information given to KYHAC by your insurance company is not a guarantee of payment. This includes information provided about covered treatments, copays, coinsurance, deductibles, and pre-authorizations. Please remember your insurance policy is an agreement between you and the insurance company and it is ultimately your responsibility to pay for any balance not paid or covered by insurance. Charges that are not covered by the given insurance company will be billed to you.

_____**Non-Covered Services:** Occasionally, your health insurance carrier, including **Medicare**, may not cover some or any of our services. If for any reason one or more of the services we provide is not covered, you will be billed for those services directly, and payment for those services will be your responsibility.

_____ **Animal Policy:** Only trained service dogs are allowed to accompany patients in the clinic.

_____**Cell Phones:** For the comfort of our patients, we prohibit cell phone conversations in the clinic. Please take all calls to the hallway and turn off all cell phones before entering the treatment rooms.

_____**Medicare/Medicaid:** Any chiropractors at Kwan Yin Healing Arts Center ***cannot*** **treat or bill services** for Medicare members, per Medicare regulations.

Please verify that you understand all our office policies by signing and dating below.

_____	_____	_____
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

NON-COVERED SERVICES WAIVER/ACKNOWLEDGEMENT

SERVICES/SUPPLEMENTS/SUPPLIES

I understand and agree to the following:

- Any and all supplements, supplies, herbs, formulas, etc. prescribed by my provider and/or purchased by me at Kwan Yin Healing Arts Center are my full financial responsibility with payment to be made at the time of service/purchase. No open products can be returned to the clinic for refund under any circumstances.
- Kwan Yin Healing Arts Center does not bill insurance carriers, health saving plans or any other like entities for any supplements, herbs, formulas, or supplies. It is my full responsibility to submit the required information to these entities for reimbursement.
- Treatment/services such as moxa, cupping, hydrotherapy, energy work, injections, IV therapy, etc. are generally not covered by insurance carriers and are my full financial responsibility *(except where specifically determined by my insurance carrier as included in the primary treatment/service being rendered and clearly stated in the insurance contract with the treating provider)*.
- It is my full financial responsibility to pay for any charges previously covered/paid by my insurance carrier to the provider and/or Kwan Yin Healing Arts Center which: **1)** is later deemed by my insurance carrier to not be "medically necessary", and **2)** has resulted in a partial or full refund request by my insurance carrier from the provider or Kwan Yin Healing Arts Center.

MEDICARE / MEDICAID

I understand and agree to the following:

- It is my full responsibility to inform staff and providers of Kwan Yin Healing Arts Center that I am a Medicare and/or Medicaid member ***prior to*** scheduling an appointment or receiving services.
- Medicare currently does not recognize, contract with, or cover alternative care (CAM) providers; any services provided to me or charges incurred by me as a Medicare member are my full financial responsibility.
- Any chiropractors at Kwan Yin Healing Arts Center ***cannot*** **treat or bill services** for Medicare members, per Medicare regulations.
- Kwan Yin Healing Arts Center is not contracted with any Medicaid plans; any services provided to me or charges incurred by me as a Medicaid member are my full financial responsibility.
- If I am a both a Medicare and Medicaid member and choose to receive services at Kwan Yin Healing Arts Center, I am fully aware that payments for any services, supplements, supplies, etc. are my full financial responsibility and **these charges *cannot* be billed** by either me or Kwan Yin Healing Arts Center to Medicare or Medicaid.

I have fully read and understand the above agreements and information.

_____	_____	_____
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

HIPAA NOTICE of PRIVACY PRACTICES & CONSENT/WRITTEN ACKNOWLEDGEMENT

I hereby consent to the use and disclosure of my protected health information by Kwan Yin Healing Arts Center for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

- I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Kwan Yin Healing Arts Center prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Kwan Yin Healing Arts Center may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Kwan Yin Healing Arts Center at the following address

3115 NE Sandy Boulevard, Suite 231
Portland, OR 97232
2330 NW Flanders St, Suite 101
Portland, OR 97210

- I understand that if I have any questions or complaints, I may submit them in writing to the address above or contact Kwan Yin Healing Arts Center by phone at: **503-701-8766**.
- I am aware that Kwan Yin Healing Arts Center reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Kwan Yin Healing Arts Center will make available a revised Notice of Privacy Practice for my review.

_____	_____	_____
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

_____ _____ _____

THIS SECTION to be COMPLETED by KWAN YIN HEALING ARTS CENTER if UNABLE to OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to, because:

- ☐ Patient declined to sign this Written Acknowledgement
- ☐ Other (please specify):

_____	_____	_____
Printed Name & Title of Employee	Signature of Employee	Date

EMAIL AND TEXT CONSENT FORM

Before sending e-mail/text communications to Kwan Yin Healing Arts Center Providers ("Kwan Yin"), please read and agree to the following information regarding the risks and conditions of e-mail/text use:

RISKS ASSOCIATED WITH USING E-MAIL/TEXT

Kwan Yin offers patients the ability to communicate by e-mail/text. However, transmitting patient information by e-mail/text has a number of risks that should be considered. These include, and are not limited to, the unintentional disclosure of your personal health information to third parties and other unintended persons. Electronic communications sent through public servers are, by their nature, unsecure and unprotected. Please be aware of this, if you choose to communicate with your providers in this fashion and understand that your decision to utilize this method of communication constitutes a waiver of privacy rights you may have regarding this information.

CONDITIONS FOR THE USE OF E-MAIL/TEXT

Kwan Yin will use reasonable means to protect the security and confidentiality of e-mail/text information sent and received. However, Kwan Yin cannot guarantee the security and confidentiality of e-mail/text communication and will not be liable for improper disclosure of confidential information. Thus, individuals must consent to the use of e-mail/text communication.

Please understand, under no circumstance should text or email communications be used in case of emergency or time-sensitive matters. Please call 911 for emergencies and go to the nearest urgent care or immediate care center for urgent matters.

Electronic transmissions can be misdirected and/or intercepted. Please exercise great care in deciding what information you should share with your providers in this fashion. For instance, individuals should avoid using e-mail/text communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

ACKNOWLEDGEMENT & AGREEMENT

I understand and acknowledge that I have read and fully understood this consent form. I request and consent to Kwan Yin using e-mail/text to communicate with me at the e-mail address(es)/telephone number(s) that I provide, and I understand that such communications may contain my protected health information, including health history, diagnosis and treatment information and demographic information. I understand the risks associated with e-mail/text communication between Kwan Yin and me, and consent to the conditions outlined above. I understand and acknowledge that I have the right to withdraw my consent in writing at any time and that this authorization shall remain in effect until I withdraw my consent. Furthermore, I understand that Kwan Yin will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

_____	_____	_____
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

CHIROPRACTIC INFORMED CONSENT TO TREAT

The State of Oregon requires that every patient be informed of the risks of, and the alternatives to, treatment prior to beginning said treatment. The following is the chiropractor's informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

I understand that a Chiropractic evaluation and treatment may include, but is not limited to, history intake, physical examination, spinal and extremity manipulation, manual soft tissue therapy, instrument assisted soft tissue therapy, therapeutic exercise, and nutritional and lifestyle counseling.

Chiropractic examination and therapeutic procedures (including spinal and extremity manipulation, ultrasound, heat application, electrotherapy, manual muscle therapy and prescribed exercises) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any medical or manual medical procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments is debated in the scientific peer reviewed literature. These complications include: injuries to the spinal discs, and rib/spinal fractures, and nerve injury. Serious complications are estimated to be in the range of 2 incidents per million for adjustments of the neck and 1 per million for adjustments for the low back. I agree to save, hold harmless, discharge and release the chiropractor from any and all liability, claims, causes of action, damages or demands in connection with Chiropractic care, Massage Therapy and/or Therapeutic Activities.

Please read the following statements carefully and initial.

_____ I affirm that I have answered all questions pertaining to medical conditions truthfully andwill update the practitioner of any changes in my health. I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the treating practitioner because it may affect care.

_____ I understand that I play an important role in my own health care. Just as the patient can choose to discontinue care at any time, Kwan Yin Healing Arts Center, Inc. reserves the right to terminate a doctor patient relationship if a patient is continually unable to comply with reasonable treatment plans.

If you have any further questions or concerns, please discuss with treating Practitioner prior to final signature.

By signing below, I hereby request and consent to the rendering of chiropractic treatment and other procedures within the scope of the practice of chiropractic in the State of Oregon. I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments from my present condition and any future conditions for which I seek treatment.

_____ _____ _____

Printed Name of Patient/Guardian/Guarantor **Signature of Patient/Guardian/Guarantor** **Date**

Health Concerns
Please list your concerns, in order of importance, including what brings you in today.

1 _____ 2 _____

3 _____ 4 _____

List all current and past long-term medications: _____

_____

Date problem began: _____ Is it getting Better ☐ Worse ☐ Staying the same ☐

It interferes with: Sitting ☐ Work ☐ Sleep ☐ Walking ☐ Hobbies ☐ Leisure ☐ Other ☐ _____

_____

Symptom Frequency: ☐ Constant (75%-100% of the time) ☐ Frequent (51%-75% of the time)

☐ Intermittent (26%-50% of the time) ☐ Occasional (0%-25% of the time)

When are symptoms the worst: ☐ morning ☐ afternoon ☐ evening ☐ do not change

Have you experienced this before, when, and how frequently? _____

_____

What decreases the symptoms: ☐ ice ☐ heat ☐ medication ☐ Stretching ☐ Nothing helps

☐ other: _____

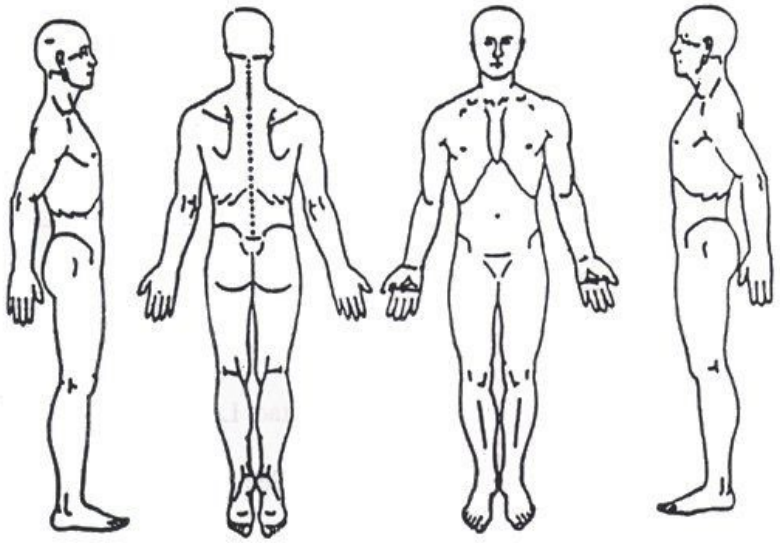
Please describe any other complaints: _____

_____

What are your goals of your treatment sessions? _____

_____

Mark current problem areas on the below picture:



Lifestyle

Tobacco use? Y ☐ N ☐ Past ☐ Quantity/type _____

Alcohol use? Y ☐ N ☐ Past ☐ Quantity/type _____

Drug use? Y ☐ N ☐ Past ☐ Quantity/type _____

Exercise? Y ☐ N ☐ Past ☐ Quantity/type _____

Caffeine? Y ☐ N ☐ Past ☐ Quantity/type _____

Alcohol use? Y ☐ N ☐ Past ☐ Quantity/type _____

Do you drink lots of water? Y ☐ N ☐ Past ☐ _____

Do you consider yourself to hold much stress? Y ☐ N ☐ Past ☐ _____

Family Health History

☐ Cancer ☐ High Blood Pressure ☐ Heart Problems ☐ Stroke ☐ Diabetes ☐ Other _____

Health History (C) Current (P) Past

c ☐ p ☐ Surgery/Hospitalization	c ☐ p ☐ Whiplash	c ☐ p ☐ High blood pressure
c ☐ p ☐ Serious injury/traumas	c ☐ p ☐ Diabetes	c ☐ p ☐ Chronic cough
c ☐ p ☐ Allergies	c ☐ p ☐ Bruise easily	c ☐ p ☐ Breathing difficulty
c ☐ p ☐ Migraines headache	c ☐ p ☐ Seizures	c ☐ p ☐ Visual disturbances
c ☐ p ☐ Rash/hives	c ☐ p ☐ Stroke	c ☐ p ☐ Atortic aneurysm
c ☐ p ☐ Chronic pain	c ☐ p ☐ Heart conditions	c ☐ p ☐ Numbess/tingling
c ☐ p ☐ Allergies	c ☐ p ☐ Bruise easily	c ☐ p ☐ Breathing difficulty
c ☐ p ☐ Vascular issues	c ☐ p ☐ Loss of sensation	c ☐ p ☐ Sinus trouble
c ☐ p ☐ Weakness/exhaustion	c ☐ p ☐ Varicose veins	c ☐ p ☐ Change in bowel/bladder habits
c ☐ p ☐ Osteoporosis/osteopenia	c ☐ p ☐ Cancer/tumors	c ☐ p ☐ Scoliosis
c ☐ p ☐ Loss of appetite	c ☐ p ☐ Bruise easily	c ☐ p ☐ Feeling of discomfort
c ☐ p ☐ Fever	c ☐ p ☐ nervousness	c ☐ p ☐ Anxiety
c ☐ p ☐ Depression	c ☐ p ☐ Bursitis	c ☐ p ☐ Auto-immune disorder
c ☐ p ☐ Disc issues	c ☐ p ☐ Nerve pain	c ☐ p ☐ TMJ disorder
c ☐ p ☐ Insomnia	c ☐ p ☐ Infections	c ☐ p ☐ Menstrual pain
c ☐ p ☐ Metal/surgical implants	c ☐ p ☐ Osteoarthritis	c ☐ p ☐ Rheumatoid arthritis
c ☐ p ☐ Tendinosis	c ☐ p ☐ Pregnant	

Any other conditions, further detail on the above or anything else you would like your provider to know: