

**Phillip Snell, DC**  
Chiropractic Physician

**Scott Haines, DC**  
Chiropractic Physician

**Justin Dean, DC**  
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: \_\_\_\_\_ 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

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Reason for coming in today: \_\_\_\_\_

Other primary health concerns: \_\_\_\_\_

\_\_\_\_\_

Current medications: \_\_\_\_\_

\_\_\_\_\_

Current vitamins/minerals/supplements: \_\_\_\_\_

\_\_\_\_\_

PAST MEDICAL HISTORY (Please include dates)

Major illnesses: \_\_\_\_\_

Past surgeries: \_\_\_\_\_

Drug allergies: \_\_\_\_\_

Please mark "N" for any problems that you now have, and "P" for any past problems:

_____ Allergies	_____ Digestive problems	_____ Pneumonia
_____ Anxiety	_____ Ear infections	_____ Stroke
_____ Arthritis	_____ Eczema	_____ Thyroid problems
_____ Asthma	_____ Headaches, frequent	_____ Trauma, major
_____ Blood disease	_____ Heart problems	_____ Tuberculosis
_____ Cancer	_____ Herpes	_____ Urinary tract infection
_____ Colds, frequent	_____ Hypertension	_____ STDs
_____ Depression	_____ Hypoglycemia	_____ Other (list below)
_____ Diabetes	_____ Nervous breakdown	_____

PAST MEDICAL CARE

Where did you last receive medical care? \_\_\_\_\_

For what reason? \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_ Last dental exam? \_\_\_\_\_

Is there anything else you would like us to know? \_\_\_\_\_

## 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: _____ (Patient)	Date: _____
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-OR-

By: _____ (Patient Representative)	Date: _____
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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# FINANCIAL POLICY AND AGREEMENT

## Cancellation & Missed Appointment Fees

A 24-hour business day notice is required for appointment cancellations. For Saturday, Sunday and Monday appointments, cancellation must occur prior to the preceding Friday at noon. If we do not receive a 24-hour business day 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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