Gail F. Ott D.C., P.C.
2230 NW Pettygrove St. Suite 110, Portland, OR 97210
Phone: 503-224-4804 Fax: 503-224-7391
Email: Info@Ottchiropracticnw.com

Patient Intake Form Date_____ File#_____

New Patient Information

First Name _____MI_____

Last Name _____

What You Prefer To Be Called_____

Street Address/Apt#_____

City/ State/ Zip_____

Email_____

Primary Phone_____

Secondary Phone_____

Preferred Method For Appointment Reminders:
(Circle One) Phone Email

Date of Birth_____ Sex: M F

SSN#_____

Emergency Contact: _____

Relationship: _____

Emer. Contact Phone_____

Marital Status (Circle One)

Single Married Divorced

Domestic Partnership Widow/ Widower

How Did You Hear About Us?
(Circle One)
Walk-in Yelp Google Doctor Ins. Co. Patient

If Patient, Their Name_____
(Patient Referrals Earn A Free Massage)

Employer_____
Occupation_____

Are We Billing Insurance for You: Yes No
If Yes, Ins. Co._____

Current Condition

Have You Ever Been Under Chiropractic Care?

Yes No

If Yes, Please Explain:

_____
_____

The Reason for Today's Visit Is a Result Of:
(Circle One)

Work Sports Auto Trauma (1-2 Weeks)
Chronic Condition (Over 2 Wks.) Other:

Please Explain_____

When Did This Condition Begin?

_____
_____

Please Describe the Symptoms:

_____
_____

Constant: Yes No Getting Worse: Yes No

Getting Better: Yes No

Have You Experienced Similar Condition(S) In the Past? Yes No

Please Explain:

_____
_____

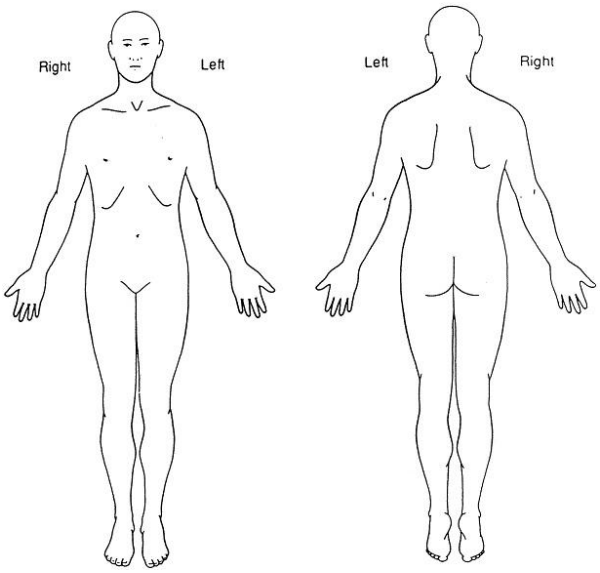
Have You Seen a Medical Physician for This Condition: Yes No Please Explain:

_____

Rate The Intensity Of Your Condition By Circling:

(Minor) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please Mark the Areas Involved With the Appropriate Symbols:
Burning= +++, Sharp Pain=XXX, Shooting Pain=!!!, Numbness=OOO, Stiffness=-----



Current Height_____ Weight_____

Do You Smoke Cigarettes: Yes No

How Much_____ How Long_____

Orthotic Inserts (Lifts/Supports): Yes No

Please Explain_____

Age of Mattress_____ Firm or Soft_____

Pregnant: Yes No Nursing: Yes No

Medications_____

Vitamins & Supplements_____

Date Of Last Physical:_____

Health History

Allergies_____ Surgeries & Dates_____

Check Any Conditions That May Apply. Please Read Thoroughly:

__ALCOHOL/DRUG ABUSE
__ANKLE PAIN
__ARM PAIN
__ARTHRITIS
__ASTHMA
__BACK PAIN
__BROKEN BONES
__CANCER
__CHEST PAIN
__DEPRESSION/OTHER DISORDER
__DIABETES
__DIZZINESS
__ELBOW PAIN
__EPILEPSY
__EYE/VISION PROBLEMS
__FAINTING
__FATIGUE
__FOOT PAIN
__GENETIC SPINAL DISORDER
__HAND PAIN
__HEADACHES
__HEARING PROBLEMS
__HEPATITIS
__HIGH BLOOD PRESSURE
__HIP PAIN
__INSOMNIA
__JAW PAIN
__JOINT STIFFNESS
__KNEE PAIN
__LEG PAIN
__LOW BACK PAIN
__LOW BLOOD PRESSURE
__MENSTRUAL PROBLEMS
__MID BACK PAIN
__MINOR HEART TROUBLE
__MULTIPLE SCLEROSIS
__NECK PAIN
__NEUROLOGICAL DISORDER
__PACEMAKER
__PARKINSON'S
__POLIO
__PROSTATE PROBLEMS
__SHOULDER PAIN
__SIGNIFICANT WEIGHT CHANGE
__SINUS PROBLEMS
__SPINAL CORD INJURY
__SPRAIN/STRAIN
__STROKE/HEART ATTACK
__STOMACH PROBLEMS
__TUMOR
__ULCER(S)
__WRIST PAIN
OTHER/EXPLANATION_____
_____
_____
_____
_____

I hereby authorize Dr. Gail Ott and whomever he may designate as assistant(s) to administer chiropractic care and any related therapies as deemed necessary.

Signature_____ Print Name _____ Date_____

For Minor Patients: I hereby authorize Dr. Ott and whomever he may designate as assistants to administer chiropractic care and any related therapies as deemed necessary to my child.

Minor's Name_____ Parent/Guardian's Name_____ Signature_____

FINANCIAL POLICY

The purpose of this policy is to assist you in maintaining a balance between the clinic (for services rendered) and your best interest. Ott Chiropractic NW feels that by maintaining an equitable balance, both communication and healing are furthered.

Please read the following carefully and **INITIAL** on the line next to the agreement that applies to you.

_____PRIVATE PAY I will pay for all services as they are rendered.

_____PPO/PREFERRED PROVIDER ORGANIZATION/GROUP HEALTH

The patient is responsible for reviewing and understanding his/her chiropractic and massage insurance benefits at the time of service.

- As a courtesy to you, we will gladly submit your medical bills to your insurance company(ies); however, all services rendered by this office will be charged directly to you, and, ultimately, you will be responsible directly to Ott Chiropractic NW for payment of your account if there is a problem with your insurance.
- I understand that I am responsible for whatever co-payment, deductible, and non-covered services that my plan has set forth at the time the services are rendered. We have a "time of service" discount for patients that pay the day services are rendered. If you are unable to pay in full, you may choose to arrange a payment plan. Please talk to one of our office staff during your visit or call us at 503-224-4804 to arrange a plan. Payment plans may not be extended to patients who have failed to make timely payments in the past.
- I understand it is my responsibility to keep my medical record up to date with current address and insurance information so that billing can be done in a timely manner. Some insurance companies require claims be submitted within 30-60 days and if new insurance coverage is not provided prior to services, it will not be possible for us to bill or collect from your insurance carrier.
- Checks returned by your bank will be subject to a $35 service fee.
- Payments received from your insurance after you have paid will be promptly returned to you.
- There will be a charge for all missed massage therapy appointments that have not been cancelled with at least 24 hours notice. The fee will be for the time that is missed.

We welcome you to Ott Chiropractic NW.
If you have any questions about your care, don't hesitate to ask.

By signing below, I certify that I understand and agree to the financial policy presented to me by Ott Chiropractic NW.

Signature_____

Print Name _____ Date_____

HIPAA Notice of Privacy Practices

THIS NOTICE IS NOT A RELEASE OF YOUR MEDICAL INFORMATION

This Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations **without your authorization**. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: **You have the right to inspect and copy your PHI.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. **You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request; even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (503)224-2804

Signature below is acknowledgement that I have received this notice of privacy practices.

Signature_____ Print Name _____ Date_____