KEYSTONE CHIROPRACTIC, LLC

Brad Vollmer, DC
685 Portland Avenue
Gladstone, OR 97027
503-908-1001
Fax 503-908-1002
keystonechiropracticpdx.com

Patient Registration Form

General Information:

Patient Name: ______________________

Address: ______________________

City: __________ State:_____ Zip Code: ________

Date of Birth: ______________ Age: ______

Social Security #: ______________________

Marital Status: ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F

Home #:___________ Cell #:___________

E-mail: ______________________

Spouse's Name: ______________________

Employment Information:

☐Employed ☐Full time Student ☐Part time Student ☐Other

Employer Name: ______________________

Address: ______________________

City: __________ State:_____ Zip Code: ________

Work Phone #: ______________ Ext: ______

Work Fax #: ______________________

Job Title: ______________________

Emergency Contact:

Name: ______________________

Phone Number: ______________________

Relationship to patient: ______________________

Whom may we thank for referring you?

____

Insurance Information:

Insurance Plan Name: ______________________

Policy owner: ______________ DOB: ________

Relation to policy owner: ______________________

Address: ______________________

City: __________ State:_____ Zip Code: ________

Phone #: ______________ Ext: ______

Fax #: ______________________

Claim #: ______________________

Group / Policy #: ______________________

ID #: ______________________

Adjustor Name: ______________________

Accident Information:

Specific Injury: ☐ Y ☐ N Date of Injury: __________

If Yes: ☐ Auto ☐ Worker's Compensation ☐ Personal Injury

To whom has a report of the accident / injury been made?

☐ Auto Insurance ☐ Employer ☐ Workers Comp. ☐ Other

Opposing Driver Name: ______________________

Opposing Insurance: ______________________

Opposing Policy #: ______________________

Opposing Claim #: ______________________

Opposing Adjustor Name: ______________________

Attorney:

Do you have an attorney representing you? ☐ Y ☐ N ☐ Not yet

Attorney Name: ______________________

Phone #: ____________ Fax #: ____________

Signature: ______________________

Today's Date: ______________________

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Authorization for Treatment

By my signature below I am authorizing treatment to be rendered and that I understand the risks and alternatives listed below. I also understand that if a treatment plan is prescribed for me, I have the responsibility to follow through with scheduled appointments and recommendations.

This office utilizes chiropractic, physical therapy, and massage therapy as conservative forms of health care with the use of manipulation, manual therapy, exercise, and in many cases physiotherapy modalities among other treatment. A history and examination and X-rays or other tests (if indicated) are performed before or during treatment to minimize potential risk factors to treatment and to make sure that this type of care is appropriate for your condition.

Potential risks and their probability of occurrence may include:

- Soreness following treatment is fairly common. This is usually mild in nature and is alleviated by the use of ice and/or heat. This is usually not an issue as treatment progresses.
- Mild burns due to physiotherapy have a rare occurrence and you should seek assistance if the therapy is uncomfortable to avoid this potential problem.
- Fracture has a very rare potential risk and is screened for in the initial history and examination. Light force or non-force techniques are used on individuals at risk (such as people with osteoporosis).
- Herniated disk has an extremely rare occurrence and usually occurs with very high force techniques.
- Stroke and/or death have an extremely rare occurrence. The manipulation posing the most risk is not performed in this office.

On the statistical basis, the majority of our patients report improvement with treatment. Some describe no change and some describe an increase in signs or symptoms with treatment. Every effort will be made to screen out those for whom treatment will not be helpful so that the potential for success will be higher.

Alternatives for care include:

- Allopathic or conventional medicine which may include the use of pharmaceuticals and/or surgery.
- Physical therapy, chiropractic, and massage therapy services, which are available at this office.
- Alternative disciplines of many types that should be undertaken with your own research.
- Doing nothing. Your symptoms may go away on their own, but underlying conditions may worsen or potentially serious problems may go undetected.

I have read the above text and understand its meaning. No financial commitment is made by signing this form.

Signature: ______________________________ **Date:** ______________________________

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Financial Policy

By signing this document, you the patient, understand and agree that your health/accident insurance policy(s) represent an arrangement between you and an insurance carrier(s). You are responsible to uphold your contractual obligation with your insurance carrier(s) if you want them to pay for services on your behalf. We may help to clarify or explain some of the points of typical insurance benefits and/or payment options, but you are responsible for your individual situation. This likely requires that you have fully reviewed your insurance policy.

By signing this document, you also understand and agree that you are responsible for the timely payment of the charges that you incur here. Per your insurance contractual obligation, you may be responsible to pay a Co-pay, Co-Insurance, Deductible or other fees as well as to cooperate with your insurance carrier(s) with additional paperwork or correspondence to assist them in assessing and managing your claim(s).

The following are general definitions of three commonly used terms associated with insurance:

Co-Pay: A fixed amount that you pay per your insurance plan for each visit that you seek with a provider. Co-Pay is due at the time of service.

Co-Insurance: A percentage that you pay (Example: 20% or 30%) per your insurance plan, based on the insurance carrier(s) accepted claim(s) information. Your Co-Insurance becomes due and payable upon the processing of the claim from your insurance carrier.

Deductible: A fixed dollar amount per your insurance plan that you are responsible to pay. Your insurance begins to pay for accepted claim(s) after your deductible has been met.

We will typically call to verify your insurance coverage for the services that you receive here. However, as most insurance carriers' state on the recording: "A quote of benefits DOES NOT GUARANTEE that those services will be accepted or paid for." If services are not accepted and/or paid for, on your behalf, you may be required to pay for them.

Our Standard Office Fee Schedule is based on the State of Oregon's Worker's Compensation Fee Schedule. You may request and obtain a written copy of our standard fee schedule if you would like.

If you do not have insurance with coverage for any and/or all of the services that you receive here or do not want to assign your insurance benefit(s), it is our standard office policy that you will be required to pay for all services at the time of your visit.

If you accrue a balance with us and it is deemed by us to be delinquent, we may utilize a Collection Agency or similar, to assist in the collection of your account. This may involve referring your account to a major Credit Reporting Agency and may affect your credit rating or score.

Signature: ______________________________ **Date:** ________________

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Assignment of Benefits

This document is to serve as an Assignment of Benefits, allowing Keystone Chiropractic to bill your insurance, on your behalf, for charges that you incur here. Please remember, you are still responsible for any charges that you incur here until paid.

By signing this form, you authorize payment of your insurance benefits directly to the provider, or Keystone Chiropractic or our respective agent(s). You also authorize this office to release and communicate all information necessary to assist with the processing and paying of your claim(s) with your insurance company or other collection agency, personal physician or other healthcare provider(s).

It is our standard office policy to not bill your insurance carrier unless this Assignment of Benefits has been agree to and signed by you. If you are unwilling to agree to this Assignment of Benefits, it is our standard office policy to collect for the entire office visit's charges at the time of service.

Your signature below indicates that you have read and accepted this Assignment of Benefits.

Signature: ______________________________ **Date:** ________________