

**Performance and Spine Chiropractic Center**

Jonathan Kinney, D.C. Heather Kinney, D.C. Justin Davis, D.C.  
19365 SW 65<sup>th</sup> Ave. Suite 104 Tualatin, OR 97062 PHONE (503) 486 – 5199 FAX (503) 486 – 5190

**Confidential Patient Information**

**NAME:** \_\_\_\_\_ **GENDER** M F  
Last Name First Name, Legal M.I.  
**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**EMAIL:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_ **SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**MARITAL STATUS:** \_\_\_\_\_ **EMERGENCY CONTACT & PHONE :** \_\_\_\_\_  
**EMPLOYER:** \_\_\_\_\_  
**Phone numbers and preferred contact (check box):**  
 [H](\_\_\_\_)\_\_\_\_-\_\_\_\_  [W](\_\_\_\_)\_\_\_\_-\_\_\_\_  [C](\_\_\_\_)\_\_\_\_-\_\_\_\_

**WHO MAY WE THANK FOR REFERRING YOU?** \_\_\_\_\_

**HIPPA PHONE AUTHORIZATION**

- \_\_\_\_\_(initial) I authorize Performance and Spine Chiropractic Center, LLC (PSCC, LLC) to leave messages on my voicemail in regarding appointments, treatment related issues and billing issues.
- \_\_\_\_\_(initial) I authorize PSCC, LLC to leave a message for, or speak to the specified individual(s) listed below in regards to information regarding appointments, treatment related issues and billing issues: (this person must provide us with your birth date). You have the right to withdraw this authorization at any time and such revocation must be in writing.
  - o At my home number (\_\_\_\_-\_\_\_\_-\_\_\_\_) with (name) \_\_\_\_\_
  - o At another number (\_\_\_\_-\_\_\_\_-\_\_\_\_) with (name) \_\_\_\_\_

**ACKNOWLEDGEMENT AND UNDERSTANDING:**

Please initial each item below.

1. \_\_\_\_\_ I hereby authorize Performance and Spine Chiropractic Center, LLC (PSCC, LLC) to provide chiropractic services and diagnosis for me, and I understand I have the right to revoke treatment at any time if I no longer wish to receive treatment.
2. \_\_\_\_\_ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans, to PSCC, LLC.
3. \_\_\_\_\_ I understand that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at PSCC, LLC. I have been informed of the \$20 fee on checks returned. I agree that I will not withhold/delay payment. I understand that I am responsible for knowing my medical benefits/limits/exclusions.
4. \_\_\_\_\_ I understand there may be certain procedures/supplies that are not covered by my insurance/3<sup>rd</sup> party settlement, and agree that I am financially responsible for those charges, however the doctor will inform me of such charges prior to providing them.
5. \_\_\_\_\_ 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.
6. \_\_\_\_\_ I authorize release of patient records to insurance company agencies requiring these records to process claims for payment, and/or to referring/consulting health care providers as your physician deems appropriate to facilitate care. I understand I have the right to request a restriction as to how my protected health information is disclosed, however PSCC, LLC is not required to agree to such restrictions. I understand I have the right to review PSCC, LLC’s Notice of Privacy Practices, which describes the types of uses/disclosures of my protected health information as well as my rights and duties to such information, prior to signing this consent document. I understand PSCC, LCC has the right to change the Notice of Privacy Practices and I may obtain a revised copy upon request.

**My signature below recognizes that I understand and agree to the aforementioned HIPPA Phone Authorization, and Acknowledgement and Understanding Agreement:**

\_\_\_\_\_  
**Patient Signature** **Date** \_\_\_/\_\_\_/\_\_\_

**AUTHORIZATION TO TREATMENT OF A MINOR**

As a parent or legal guardian, I hereby authorize treatment for the following:  
(Patient’s full name) \_\_\_\_\_ (Date of Birth) \_\_\_\_\_  
to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

\_\_\_\_\_  
**Signature of Parent/Guardian** **Date** \_\_\_/\_\_\_/\_\_\_



Patient Name: \_\_\_\_\_

For Re-exams/Updates Only—**please initial** if there has been no change on this page since your last visit: \_\_\_\_\_

**If you have ever been treated for a listed condition in the past, please check it in the Past column.**

**If you are currently under the care of a medical professional for a listed condition, check it in the Present column.**

- | Past                     | Present   |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain (723.1)                            |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain (724.1)                      |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain (724.2)                        |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain (719.41)                       |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in Upper Arm or Elbow (719.42)          |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain (719.43)                          |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain (719.44)                           |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in Upper Leg or Hip (719.45)            |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in Lower Leg or Knee (729.5)            |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in Ankle or Foot (719.47)               |
| <input type="checkbox"/> | <input type="checkbox"/> Headache (784.0)                             |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain (526.9)                             |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes (250.0)                             |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure (401.9)                  |
| <input type="checkbox"/> | <input type="checkbox"/> Chest Pains (786.50)                         |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Attack (410.9)                         |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke (436)                                 |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer (99.1)                                |
| <input type="checkbox"/> | <input type="checkbox"/> Blood Disorder (790.6)                       |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma (493.9)                               |
| <input type="checkbox"/> | <input type="checkbox"/> Swelling/Stiffness of Joint(s)               |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis (716.9)                            |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis (714.0)                 |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting (780.2)                             |
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness (780.4)                            |
| <input type="checkbox"/> | <input type="checkbox"/> Pregnancy (V22.2)                            |
| <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills                          |
| <input type="checkbox"/> | <input type="checkbox"/> Hormonal/Estrogen Replacement                |
| <input type="checkbox"/> | <input type="checkbox"/> Medications: _____                           |
| <input type="checkbox"/> | <input type="checkbox"/> Vitamins/Herbs _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> Hospitalization/Surgeries: _____             |
| <input type="checkbox"/> | <input type="checkbox"/> Liver (573.9) / Gallbladder (575.9) problems |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones (592.0)                        |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders (by condition)              |
| <input type="checkbox"/> | <input type="checkbox"/> Colitis (558.9)                              |
| <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS (042)                               |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis (473.9)                    |
| <input type="checkbox"/> | <input type="checkbox"/> Irregular Menstrual Flow (626.4)             |
| <input type="checkbox"/> | <input type="checkbox"/> Breast Soreness/Lumps (611.72)               |
| <input type="checkbox"/> | <input type="checkbox"/> Painful Urination (788.1)                    |
| <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain (789.0)                       |
| <input type="checkbox"/> | <input type="checkbox"/> Heartburn/Indigestion (787.1)                |
| <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash (692.9)               |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____                                 |

- | Past                     | Present  |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Tobacco (305.1)                               |
| <input type="checkbox"/> | <input type="checkbox"/> Alcohol (305.0)                               |
| <input type="checkbox"/> | <input type="checkbox"/> Drug or Alcohol Dependence (303.9)            |
| <input type="checkbox"/> | <input type="checkbox"/> Coffee/Tea/Caffeinated Soft Drinks: Cups/Cans |

Weight: \_\_\_\_\_ pounds Height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Doctor's additional comments/general health concerns:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PERFORMANCE AND SPINE CHIROPRACTIC CENTER, LLC**  
**19365 SW 65<sup>TH</sup> AVE. SUITE 104 TUALATIN OR 97062**  
**PHONE: (503) 486 – 5199 FAX: (503) 486 – 5190**

**WORKERS COMPENSATION HISTORY FORM**

Name: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

1. Name of employer at the time of accident: \_\_\_\_\_

2. Length of time worked there prior to accident: \_\_\_\_\_

3. Type of work being done at time injury: \_\_\_\_\_

4. In your own words, please describe accident: \_\_\_\_\_

5. Have you been treated by another doctor for this accident? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list doctor's name and address: \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

How long were you treated by this doctor? \_\_\_\_\_

6. Are you:  improved  unchanged  getting worse

7. What types of medicines are you taking? \_\_\_\_\_

Do these medicines help?  Yes  No  Don't know

8. Have you had physical therapy?  Yes  No If yes, how often? \_\_\_\_\_

Daily  Every other day  Several times a week  Weekly

Every other week  Monthly  Other

9. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

Yes  No  Don't know

If yes, describe: \_\_\_\_\_

Were these similar complaints the results of previous accident(s)?

Yes  No  Not Applicable

Please provide details of accident(s): \_\_\_\_\_

10. Have you had any other serious accidents which required medical care?

Yes  No

Describe: \_\_\_\_\_

11. Have you had any serious illnesses that required hospitalization?

Yes  No

Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Workers' Compensation ELIGIBILITY CHECK-LIST AND FINANCIAL POLICY**

**Performance and Spine Chiropractic Center, LLC  
19365 SW 65<sup>th</sup> AVE Ste. 104 Tualatin, OR 97062**

**PHONE (503) 486 – 5199  
FAX (503) 486 – 5190**

Date of injury: \_\_\_\_\_ Time of injury: \_\_\_\_\_  
STATE OF OR Claim#: \_\_\_\_\_ **OR SELF-INSURED** Claim#: \_\_\_\_\_  
Name of Self-insured Company: \_\_\_\_\_  
Name of claims adjustor: \_\_\_\_\_ Adjustor's Phone Number: \_\_\_\_\_  
Location/Address of Accident: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Name of your Supervisor: \_\_\_\_\_ Phone \_\_\_\_\_  
Address of Employer: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Dr who opened your claim: \_\_\_\_\_ Phone \_\_\_\_\_  
Address of Dr. who opened your claim: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Did your Dr. write a referral to get Chiropractic care? \_\_\_\_\_ Please give it to the office staff!

**FINANCIAL POLICY**

As a patient of this office, you are directly responsible for all charges incurred. If your worker's compensation claim is denied you are fully responsible for prompt payment. If your claim cannot be verified as open and payable, you will be required to pay cash for your visit(s). If Worker's Compensation denies any services or deems them to be not medically necessary, you will be responsible for prompt payment. All supplies/supplements must be paid for before leaving the office and are not billed to Worker's Compensation. If you refuse to sign below, you acknowledge that you will be required to pay at the time of your visit(s).

**HIPAA Notification & Authorization to Release Information:** I hereby authorize the office of Performance and Spine Chiropractic Center, LLC to release necessary information to file a medical lien to secure payment for care received from PSCC should the need arise. The information on the medical lien is made public record. It identifies the patient, their address, 3RD Party, insurance parties involved, date of accident, location of accident and gives a general medical description of conditions being treated: "Soft tissue injuries to the spine, paravertebral structures and extremities."

\_\_\_\_\_  
Print Patient/Guardian Name Signature of Patient/Guardian Date

**TO BE COMPLETED BY OFFICE STAFF**

**VERIFICATION OF WORKERS' COMPENSATION CLAIM**

**Receive Phone Number of Claim Adjustor**

Date: \_\_\_\_\_ Spoke with: \_\_\_\_\_ Phone: \_\_\_\_\_  
Claim Adjustors Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Has the claim been "allowed" yet? Yes / No Is the claim "pending"? Yes / No  
\*Diagnostic codes allowed: \_\_\_\_\_  
Attending Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Is there a referral for chiropractic from the attending? Yes or No  
Mail Claims To: \_\_\_\_\_  
\_\_\_\_\_ Claim # \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Additional Information: \_\_\_\_\_

**PERFORMANCE AND SPINE CHIROPRACTIC CENTER, LLC**  
**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND MASSAGE CARE**

Chiropractic treatment consists of manipulations of joints and soft tissues, using the hand and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Some patients will feel some stiffness and soreness following the first few days of treatment. These are normal and not a cause for concern. There are different techniques used in Chiropractic spinal manipulations. There are also alternatives to Chiropractic care, including but not limited to: Physical Therapy, Massage therapy, Osteopathic manipulations, and Medical care. There are also material risks inherent in the above listed alternatives, which should be discussed between you and the specialty care provider. You also have the option of not seeking any care. The risk of remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain risks which may arise during the exam and treatment. While rare, those complications include: strokes or stroke-like conditions, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, pathological fracture, cervical disc protrusions, cervical dislocations, costovertebral strains, rib fractures, costochondral separations, compression of the cauda equina. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise clinical judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. The risks of massage are bruising, local tenderness, and the release of toxins in the body. There are also risks in taking nutritional supplements, please contact your Primary Care Physician/ health care practitioner before using any nutritional products, including those dispensed in this office.

I have read or have had read to me the above explanation of the nature and purpose of chiropractic adjustments, other alternatives/ procedures for care, massage, and possible risk. I have also had the opportunity to ask questions about its content and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended, and listed below. Having been informed of the risk, **I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, and diagnostic x-rays-if warranted, massage, and the use of natural substances, such as vitamins, minerals, or other natural substances on me or on the patient name below, for whom I am legally responsible, by the doctor of chiropractic named below and/or license doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as backup for the doctor of chiropractic named below and by the Licensed Massage Therapist listed below, including those working at the clinic or office listed below or any other office or clinic.** I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

The anticipated results of the proposed treatment as described by Dr./LMT \_\_\_\_\_ is: (to be completed by the Doctor / LMT)\_\_\_\_\_

\*\*\*\*\*

*To be completed by patient:*

*If patient is a MINOR, this section to be completed by patient's legal guardian, legally responsible adult.*

\_\_\_\_\_  
**PRINT Patient's Name**

\_\_\_\_\_  
**PRINT Patient's Name**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
**PRINT Name of Patient's Guardian**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient's Guardian

\_\_\_\_\_  
Date

***To be completed by Doctor/ LMT***

19365 SW 65<sup>th</sup> Ave. Suite 104  
Tualatin, OR 97062

PHONE: (503) 486 – 5199

FAX: (503) 486 – 5190

Name of Doctor(s)/LMT treating this patient:

Jonathan Kinney, D.C.

Heather Kinney, D.C.

Justin Davis, D.C.

Licensed Massage Therapist

\_\_\_\_\_  
Witness to Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Translated by:

\_\_\_\_\_  
Date