Moore Chiropractic Clinic

1709 NE 27th St., Suite H • McMinnville, OR 97128

Halley Moore, D.C. • Phone: 503-472-1477 • Fax: 503-472-1478

NEW PATIENT REGISTRATION

Today's Date _____

Name _____ Acct# _____
Last First MI

Address

_____*
(Complete Mailing) Street Apt# City State Zip

Social Security # _____ – _____ – _____ Date of Birth_____

Primary Phone* (_____) _____ - _____ ☐ home ☐ cell ☐ work

Secondary Phone* (_____) _____ - _____ ☐ home ☐ cell ☐ work

Email Address: _____*

Employer_____ Occupation_____ Phone (_____) _____ - _____

Emergency Contact_____ Relationship_____ Phone (_____) _____ - _____

Reason for this visit: ☐ routine ☐ accident, date _____ ☐ illness ☐ other: _____

* Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

I have read and understand that this alternative is available to me _____ _____
Signature Date

RESPONSIBLE PARTY INFORMATION

Name (Guarantor) _____
Last First MI

Relationship to Patient _____

Address _____ Phone (_____) _____ - _____
Street City State Zip

Employer_____ Address _____

Employer Phone (_____) _____ - _____

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ACKNOWLEDGEMENT AND UNDERSTANDING

PLEASE READ AND INITIAL EACH ITEM BELOW.

1. _____ I hereby authorize Moore Chiropractic Clinic to provide Chiropractic services for me.

2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Moore Chiropractic Clinic.

3. _____ 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.

4. _____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Moore Chiropractic Clinic, 1709 NE 27th St., Suite H, McMinnville, OR 97128.

5. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

_____ _____

Patient Signature Date

_____ _____

Grantor Signature Relationship to Patient

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ Date of Birth _____

Patient's full name

to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Signature_____ Witnessed by _____

(Parent or Legal guardian)

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CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any 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 (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

_____ _____

Patient Signature Date

Please read the following carefully and initial each statement.

_____ I understand that if I have any prosthetics or surgical implants (including breast implants, pacemaker, an artificial joint, etc.), I should discuss this with the physician because it may affect care.

_____ I understand that if I may become pregnant, I should discuss this with the physician because it may affect care. Devices like interferential current is a contraindication with pregnancy.

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

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

We believe that all patients should be treated in a manner that respects their basic rights as human beings. You, as patients, have the right to:

1. Voice grievances or concerns about your care, or about the manner in which you were treated by the doctor. If you have concerns about your care, please contact the doctor.
2. Receive clear and complete information about your care and participate in the decisions concerning your treatment. If you have concerns about insurance or billing, please contact the doctor.
3. Be treated with respect and courtesy by all those involved in providing care and information.
4. Privacy during interviews and examinations. All information about a patient's care and records will be treated in a confidential manner.

Patient Responsibilities

1. Be as accurate and complete as possible when providing information about your medical history or condition.
2. Cooperate in following instructions given to you by those providing your health care.
3. Read and cooperate with the instructions provided by your doctor.
4. Ask for clarification about any aspect of your health care benefits that you do not fully understand.
5. Keep scheduled appointments or give adequate notice of delay or cancellation.
6. Treat those caring for you with respect and courtesy.

PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (4 pages) for Moore Chiropractic Clinic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application for Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Print the Patient Name

Moore Chiropractic Clinic

PO BOX 86 • 1226 HWY 99W • Dundee, OR 97115
Halley Moore, DC • Phone: 971-264-9373

APPOINTMENT CANCELLATION POLICY

We strive to render excellent chiropractic care to you and the rest of our patients at Moore Chiropractic Clinic. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **24 hours'** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature of Patient Date