

HARVARD CHIROPRACTIC CLINIC PC

James E. Medak DC

Sandra L. Medak DC

Thank you for choosing Harvard Chiropractic Clinic

Our goal is to help people get well and stay well. We do this by teaching how to maintain health through lifestyle and dietary changes. We work with patients as a coach would work with an athlete. This relationship must be 50/50! The coach cannot do all the work, but is there to help guide and support the athlete on the athlete's quest for optimal health

- ❑ **The first visit will be approx *one hour*. Please arrive 15minutes before your scheduled time.**
- ❑ **Wear comfortable clothing to your appointment**
- ❑ **Women please wear pants (no skirts) to your visits**
- ❑ **Avoid wearing perfumes, essential oils, scented hair products, scented lotions**
- ❑ **Please bring a list & description all prescriptions and supplements currently taking**
- ❑ **For BioMeridian Scans, please drink 8oz of water prior to your appointment**

Driving Directions: Our office is located on the corner of Harvard and Kenwood Streets in Roseburg, Oregon. Turn off Harvard onto Kenwood and we are the first driveway on the left.

**We look forward to being able to partner with you
in achieving your health goals!**

WELCOME TO HARVARD CHIROPRACTIC CLINIC

Mr. Mrs. Ms. (circle one)

Last Name _____ First Name _____ MI _____
Name you prefer to be called _____ Sex: M or F (circle one)
Street Address _____ Employer Name _____
PO Box _____ Occupation _____
City _____ State _____ Zip _____ Employer Address _____
Home Telephone _____ City _____ State _____ Zip _____
Social Security # _____ Work Telephone _____
Birth Date _____ Age _____ Drivers License # _____

Spouse or Parent Information

Last Name _____ First Name _____ MI _____
Social Security # _____ Birth Date _____
Employer _____ Work Telephone _____
Occupation _____

In case of emergency please contact _____ Phone _____

How did you find out about us? _____ A patient of ours or friend. What is their name? _____
_____ Yellow Pages _____ Your Doctor _____ Sign Out Front _____ Other _____

Do you have Insurance? Y or N _____ If yes, may we have a copy of your card/cards?
If not, do you intend to pay with _____ Cash _____ Check _____ Credit Card?
Person financially responsible for this account _____

I understand and agree that (regardless of my insurance status), I am responsible for the balance of my account for any professional services rendered. I give my permission for Harvard Chiropractic Clinic to release any information to my insurance company that is necessary to receive payment. I have read and completed all the information on this sheet. I certify this information is true and correct to the best of my knowledge. I will notify Harvard Chiropractic Clinic of any changes in my status or the above information.

Signature _____ Date _____

OFFICE USE ONLY

Pt # _____ FOV _____ LOV _____
Dx _____
Level _____ DOI _____

Patient Health Questionnaire

ACN Fax: 503.691.1152 Phone: 503.692.9095

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ACN Use Only rev 8/98

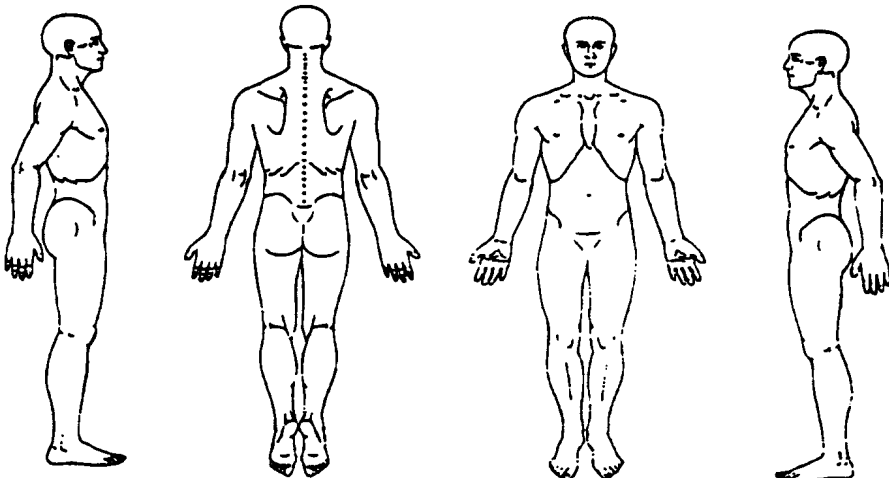
Patient Name _____

Date _____

When did your symptoms start? _____

Describe your symptoms and how they began: _____

Indicate on the pictures below where you have pain or other symptoms



How often do you experience your symptoms?

- 1-Constantly (76-100% of day)
- 2-Frequently (51-75% of day)
- 3-Occasionally (26-50% of day)
- 4-Intermittently (0-25% of day)

What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling

How are your symptoms changing?

- 1-Getting Better
- 2-Not Changing
- 3-Getting Worse

What is the intensity of your symptoms at their:

- | | | | | | | | | | | |
|-------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | None | | | | | | | | | Unbearable |
| worst | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| best | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Who have you seen for this episode of your symptoms?

- No one
- Other Chiropractor
- Medical Doctor
- Physical Therapist
- Other

When and what treatment? _____

Have you had the same or similar symptoms in the past? Yes No

If you have received treatment in the past for the same or similar symptoms, who did you see?

- This office
- Other Chiropractor
- Medical Doctor
- Physical Therapist
- Other

What tests have you had for your symptoms?

- Xrays
- CT Scan
- MRI Scan
- Other

What is your occupation?

- 1-Professional/Executive
- 2-White Collar/Secretarial
- 3-Tradesperson
- 4-Laborer
- 5-Homemaker
- 6-FT Student
- 7-Retired
- 8-Other

If you are not retired, a homemaker or a student, what is your current work status?

- 1-Full-time
- 2-Part-time
- 3-Self-employed
- 4-Unemployed
- 5-Employed, off work due to restrictions
- 6-Other

As a result of your symptoms are you restricted in your ability to perform work and/or daily activities?

- Yes
- No

Describe your restrictions _____

What type of regular exercise do you perform?

- 1-None
- 2-Light
- 3-Moderate
- 4-Strenuous

What is your height and weight?

Height

--	--	--

Feet Inches

Weight

--	--	--

 lbs.

Patient Signature _____

Harvard Chiropractic Clinic

Financial Policy

Thank you for choosing our office. Our doctors and staff are committed to providing health care for healing.

CASH

If you do not have insurance, **our payment policy is to have patients pay for services the day care is received.** Payment may be made by cash, check, VISA, Master Card, or Discover. If other arrangements must be made, please talk to our office manager prior to receiving care.

INSURANCE

We will file insurance claims to your **primary carrier only**, unless you have a **Crossover** set up with your secondary insurance carrier. A crossover is an agreement to coordinate benefits between your primary and secondary carriers. The primary pays their part and sends an explanation of benefits to your secondary and they pay their part. If you do not have a crossover set up, **you will be asked to pay your co-insurance at the time of service** and we will give you a receipt with all the information you need to bill your secondary when you receive the explanation of benefits from your primary. If you need more information on how to set this up, please ask our office staff.

We will normally bill your insurance company as a courtesy to you. You are responsible to verify your insurance coverage. Coverage varies from carrier to carrier, as does the percentile that each carrier uses to calculate the fees they will pay. Your care may exceed their definition of what is necessary for your health. It's important for you to understand that professional care is provided to you and not to your insurance company. Your insurance contract is between you and your carrier. Any services not covered or coverage reductions by your insurance company are your responsibility. Our office will NOT be responsible to settle a dispute with your insurance company over any claim. Waiting for insurance payments is a courtesy that may be withdrawn at any time.

MEDICARE

Our office submits Medicare claims for you. If you have a **Crossover** set up, Medicare will automatically bill your secondary insurance carrier. If you do not have a **Crossover** set up, **we ask you pay your co-pay at the time of service.** We will give you a receipt that will include all of the necessary information you need to bill your secondary carrier when your explanation of benefits comes to you from Medicare. If you need more information on how to set up a crossover, please ask our office staff.

We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice. If you have questions concerning this or any other matter, please speak with the receptionist or office manager. Thank you.

I give my permission for Harvard Chiropractic Staff to leave messages at the phone numbers I have provided.
_____ YES _____ NO

I give my permission for Harvard Chiropractic Clinic to release any information to my insurance company that is necessary to receive payment. I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature

Date