1530 E. 1st St
Newberg, Oregon 97132
P: 503 538 1232 F: 503 538 7339
www.weberchiropracticclinic.com

WEBER CHIROPRACTIC

First Name: _____ Last Name: _____

Birthdate: ___/___/___ Email Address: _____

Cell Phone: _____How did you hear about us? _____

Ever experienced a head or spinal injury? _____

Please list below any medications and supplements you may be taking:

_____

Please list any allergies you may have:

_____

Please list any past surgeries you may have:

_____

Are you Pregnant? (N/A for not applicable) _____

Have you had a massage therapy before? _____

Major condition/complaint you'd like to improve: _____

AREAS TO FOCUS: _____AREAS TO AVOID: _____

Do you smoke? _____ Average hours of sleep per night: _____

How often do you exercise? _____

Weekly caffeine consumption: _____

Weekly alcohol consumption: _____

I understand all of the above information and have informed the Massage Therapist of all my known medical conditions and medication. I will keep my Massage Therapist updated of any changes.

_____

Patient's Signature

Informed Consent to Massage Therapy

I hereby request and consent to the performance of massage therapy and other procedures including but limited to myofascial release, cupping, scrapping/IASTM, hot packs/towels, cryotherapy by Weber Chiropractic LLC. The following points have been explained to me, to my satisfaction, and I have had an opportunity to discuss them with the therapist. and/or other clinic personnel.

-As with the practice of medicine, the practice of massage therapy is not an exact science, but relies upon information related by the patient, information gathered during the initial visit, and the therapist's interpretation thereof, as well as the therapist's judgement and expertise in working with similar cases.
-Because a massage therapist must be aware of existing physical conditions I have stated all my known medical conditions and take it upon myself to keep the massage therapist update on my physical health. This massage is not a substitute for a medical exam and it is recommended that I see a physician for any physical ailments I might have. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist prescribes neither medical treatment nor pharmaceuticals nor performs any spinal manipulations.
-It is not reasonable to expect my therapist to be able to anticipate, or explain all possible risks and complications of a given procedure on any particular visit. And I wish to rely on the therapists to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest.
-An undesirable result, or side effect, does not necessarily indicate error in judgement or an improper treatment.
-As with any health care procedure there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to bruising, soreness, sprains/strains. These complications are extremely rare occurrences.

Clinic Account Policy
-Payment is expected at the time of service.
-As a service to you, we will bill your insurance company. We will ask you to pay the amount your insurance company will not pay at the time of each office visit. Ie; deductible, percentage, co-pay, non-covered service.
-We make every effort to get accurate information from insurance companies. However, insurance companies make mistakes. For example, sometimes they tell us they'll cover certain charges and then not pay them when they receive the billing. For this reason, we periodically review accounts and may have to inform you of a balance due.
-Information received from the insurance company IS NOT A GUARANTEE OF BENEFITS. You are responsible for all charges incurred in this office.
-If you have a personal injury (automobile accident) account, we'll bill your insurance company. The insurance company may not cover 100% of your bill. You are responsible for the difference. We'll keep you updated on the payment activity on your account, and ask that you keep us updated on any new information you may receive regarding your account. We reserve the right to charge 18% interest per year on any outstanding claims over 30 days.
-Weber Chiropractic has a 24 hour cancellation policy, a $60 fee will be charged for missed appointments.

I have read the above consent, or had it read to me and I am comfortable with the information provided and consent to chiropractic treatment and management on that basis.

_____ _____ _____

Patient's Name (printed) Patient's Signature (Parent or Guardian) Date

Weber Chiropractic LLC Notice of Privacy Practices

_____ I have received a copy of Weber Chiropractic's Notice of Privacy Practices.
Initial

Weber Chiropractic LLC Dr. Anthony Weber 1530 E 1st St, Newberg Oregon 97132
Office: 503-538-1232 or 503-538-7338

Notice of Privacy Practices

We want you to know how your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company provided by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company requires for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all the precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the Chiropractic Physician has the right to refuse to give care.

I have read and understand how my patient health information will be used and I agree to these policies and procedures.

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