ACKNOWLEDGEMENT OF RECEIPT OF
Notice of Privacy Practices
of BACK to Health Clinic & Natural Recovery Massage

Patient Name: _____ Patient# or SSN: _____

Address: _____ City: _____ State: _____ ZIP: _____

Email: _____ Phone: (____)_____-_____ Cell/Home/Wk

I have been given or offered a copy of the Notice of Privacy Practices of BACK to Health Clinic and Natural Recovery Massage, which describes how my health information is used and shared. I understand that either BACK to Health Clinic or Natural Recovery Massage has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official or by visiting the Facility website at salembackdoctor.com.

My signature below acknowledges that I have been provided or offered a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Printed Name

_____

Personal Representative's Title ***(e.g. Guardian, Executor of Estate, Health Care Power of Attorney)***

For Clinic Use Only: Complete this section if you are unable to obtain a signature.

1. If the Patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the patient's or personal representative's signature on the Acknowledgement:

Completed by:

_____ _____

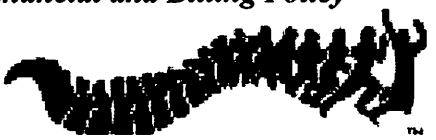
Signature of Clinic Representative Date

_____

Printed Name

Scan or file original in Patient's Records.

BACK to Health Clinic
Financial and Billing Policy



General Billing Information

All new patients must provide picture ID at their first visit and as requested thereafter, as required by federal law. Inability to show valid picture ID will force us to reschedule your appointment for a later time when valid picture ID can be provided. All new patients must complete and sign new patient paperwork.

All out of pocket costs are due at the time of service. We accept Visa, MasterCard, Discover and Care Credit for your convenience. On occasion, coinsurance and deductibles may only be determined after your insurance has been billed. This may leave a balance on your account. If you have a balance, invoices will be sent at the beginning of each month. Invoiced accounts that remain unpaid by the next billing cycle will be subject to a $10 late fee. Accounts with returned checks will be charged a $30 returned check fee. An account may be sent to a collections agency at any point in time once it has become delinquent, at the discretion of the BACK to Health Clinic billing staff. Failure to provide 24 hour notice prior to appointment cancelation will result in a $10 fee. Please direct all billing inquiries to 503-689-1929 ***phone payments are gladly accepted***

Self Pay Patients

All self pay patients are required to pay at time of service. We accept Visa, MasterCard, Discover and Care Credit. Our "My Wellness Card" program is also a great option for individuals or families without chiropractic coverage. It's affordable, flexible and can be transferred or gifted. Please ask our receptionist for more details or pick up a brochure at the front desk. All durable medical equipment (e.g. pillows, braces and supplements) must be paid for at time of service.

Medical Records

Medical records will be provided to other healthcare providers for coordination of care at no cost. Should you desire a copy of your records for yourself, we will charge reasonable, cost based fees per, ORS 192.521. Personal copies are $30 for up to the first 10 pages and .50 cents for each additional page. Copy fees must be paid in full and an authorization signed prior to copies being prepared. Please be prepared to show picture ID when picking up copies of your medical records. Medical records will only be release to the person or entity listed on the release of medical records form. Medical record requests may take up to 30 days to complete.

Private/ Group Health Insurance

(Please remember that insurance estimates are based on information provided by your insurance company. Eligibility and benefits quoted by insurance are an estimate only and not a guarantee of payment. Please have your updated insurance card ready to show our receptionist at the time of your visit)

Your insurance is a contract between you and your insurance carrier, and may involve your employer. We have no control over your benefits. You are ultimately responsible for checking with your plan directly to see what chiropractic benefits you have and to obtain any needed referral or authorization from your primary care provider or plan. Some insurance contracts may not cover all provided services. Services are provided based on medical necessity, NOT the assumption that the charges will be paid by the insurance. **You are ultimately responsible for treatment costs that are not covered by insurance.** It is your responsibility to provide us with any updates or changes to your insurance. Failure to do so could result in denial of your claims and payment would automatically become your responsibility. All out of pocket costs are due at time of service. We accept Visa, MasterCard, Discover and Care Credit.

Medicare

BACK to Health Clinic does accept and bill Medicare. If you have a secondary insurance or a supplement, please provide it at the time of service. We do not participate with all Medicare secondary insurers. You are responsible for all amounts not paid, due to non participation with your secondary insurer. You are also responsible for all deductibles and coinsurance left by Medicare. You may be asked to sign an Advanced Beneficiary Notice for any maintenance care or service that we believe may not be covered by Medicare.

Oregon Health Plan/ Medicaid

BACK to Health Clinic is currently unable to accept Oregon Health Plan/ Medicaid, for chiropractic treatment. If Oregon Health Plan (Medicaid) is your secondary insurer, costs not covered by your primary plan will be solely your responsibility.

Motor Vehicle Collision Patients

BACK to Health Clinic gladly treats patients injured in Motor Vehicle Collisions (MVC). We will bill the insurance of the vehicle you were occupying at the time of the injury directly. If you have private insurance, you are required to provide that information at the beginning of your treatment. This information will be used in the event that you exhaust the personal injury benefit provided by your auto policy. In this event, you will be responsible for any co-pays, deductibles or coinsurance associated with your private health insurance policy.

Workers Compensation Patients
BACK to Health Clinic gladly treats patients with work related injuries. We may treat for a total of 60 days or 18 visits on the initial claim. Treatment beyond this timeframe may require a referral from an attending Physician. Please inform the office if you receive notice that you are being enrolled in a Managed Care Organization (**MCO**) as this will affect the circumstances under which we may treat you. We will bill your employer's workers compensation insurer directly. If you have private insurance, you are required to provide that information at the beginning of your treatment. This information will be used in the event that your claim is denied. In this event, you would be responsible for any deductibles, co-pays or coinsurance associated with your private health plan. These costs will be collected only after a denied, un- appealed claim.

Irrevocable Doctor's Lien and Assignment or Right to Recovery
In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care through the doctors of BACK to Health Clinic, each new patient treating for a Motor Vehicle Collision (MVC), Workers Compensation, Slip Fall, or any type of third party liability claim, whether you have an attorney or not, must sign a Doctor's Lien to guarantee us payment for services rendered, against any settlement you might receive on your case. Your signature also provides us permission to forward your unpaid bills to the attorney for coverage instead of having to bill you directly. Doctors Lien's allow your attorney to pay any outstanding bills related to your claim to BACK to Health Clinic directly.

Medical Massage
BACK to Health Clinic provides medical massage, performed by Certified Medical Massage Therapists and Certified Chiropractic Assistants. **Medical Massage** is ***Injury Care*** by ***Dr's Referral*** for ***Diagnosed Conditions***. It focuses on treatment of pain, spasm, swelling and/or limited motion, *often* due to traumatic injury. A medical massage is currently $208 Dollars for 60 minutes ($52 per unit). Necessary units are determined by referring physician, and will not be performed until a Dr's referral is obtained. No discounts, certificates or special promotions will be honored for medical massage. ***Our therapists will not perform medical massage under pretense or cost of a wellness massage.*** Gift cards or referral certificates may ***not*** be used for ***medical massage***.

Wellness Massage
BACK to Health Clinic no longer offers wellness massage to the public.

Department of Transportation (DOT) Physicals
Our doctors are licensed Certified Medical Examiners by the Federal Motor Carrier Safety Administration (FMCSA) National Registry. A copy of your exam results will be furnished to you and a medical examiners certificate will be provided to you for proof of passed exam. DOT Physicals will not be billed to insurance and must be paid prior to your exam. If you fail the exam, you are still required to pay. A onetime courtesy retake will be provided at no cost in the event that you need to see another provider to resolve a medical issue that caused you to fail the exam. Retake exams must be done within 90 days of failed exam. A medical examiners certificate is good for up to 24 months.

Sports Physicals
Our doctors perform sports physicals year round. The doctor will fill out the necessary documentation to be provided to the entity requiring the physical. Sports Physicals are currently $35. This must be paid prior to exam by cash, credit or debit. We do not accept checks for these exams. Sports Physicals will not be billed to private/ group health insurance. BACK to Health Clinic is unable to perform physicals for "Boy Scouts of America". They have specific criteria and can provide you with a list of approved examiners in your area.

PATIENT AGREEMENT AND ASSIGNMENT OF BENEFITS: I hereby assign Back to Health Clinic, the insurance benefits that are otherwise payable to me for charges relating to my care. I also direct my insurance company to make payment directly to this clinic on my behalf. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not I have insurance, and agree to pay all fees, including attorney fees, associated with the collection of this debt. I hereby authorize assignee to release all information necessary to secure payment. Please let us know if you have any questions about our Financial and Billing Policy. Your signature below will confirm that you have *read* and *understand* our Financial and Billing Policy.

Signature of Guarantor _____ **Date** _____

BACK to Health Clinic
4630 River Rd. N., Suite A
Keizer, OR 97303
P# 503-304-2225 F# 503-304-2226
Jeffery W. Baker, DC.,PC- Cody A. Leder, DC- Alicia Jeffers, DC- Gideon Tarnasky, DC

BACK  to Health Clinic

Jeffery W. Baker, DC., PC- Cody A. Leder, DC- Alicia Jeffers, DC- Gideon M. Tarnasky, DC.

PERMISSION TO RELEASE CONFIDENTIAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE.

IMPORTANT NOTICE: The law prohibits the release of confidential medical information to an entity without the written voluntary consent of the undersigned patient.

Name of Patient: _____ Date of Birth: _____

- ❖ BACK to Health Clinic may leave messages on my phone YES NO
- ❖ I authorize BACK to Health Clinic to confirm appointments and/or discuss information regarding my medical condition with: (spouse, relatives, friends)

_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship

If you do not want any information given to anyone other than yourself please initial here_____

I understand this Authorization. I also understand that the information used or disclosed may be subject to re-disclosure by the recipient and no longer protected under federal law. I understand this document is not a release of medical *records*.

_____	_____
Signature of Patient	Date
_____	_____
Signature of Legal Representative	Date
_____	_____
Printed Name of Legal Representative	Date

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. Back to Health Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

JEFFERY W. BAKER D.C., P.C.
dba BACK to Health Clinic
4630 River Rd N., Suite A
Keizer, OR 97303

ADDRESS SERVICE REQUESTED

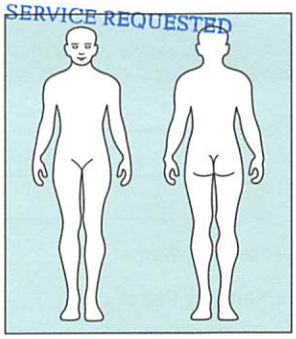
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test _____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

JEFFERY W. BAKER D.C., P.C.
dba BACK to Health Clinic
4630 River Rd N., Suite A
Keizer, OR 97303

MEDICATIONS

_____
_____
_____

Pharmacy Name_____

Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

BACK to Health Clinic

Jeffery W. Baker, D.C., & Associates
Alicia Jeffers, D.C. ▪ Gideon M. Tarnasky, D.C. ▪Cody A. Leder, D.C

ORTHOPEDIC AND NEUROLOGICAL SPINAL EXAM

Patient Name: _____ Patient DOB: _____ Date_____

OBJECTIVE FINDINGS

Age_____ Height _____ Weight _____ Temp _____ Eyes _____ Ears _____ Mouth _____
Blood Pressure R _____/_____ L _____/_____ Pulse _____ Throat _____ Heart _____ Abdomen _____

STANDING EXAM

Gait Evaluation _____
Rhomberg Test _____
Trendelenberg (hip)_____
Squat Test _____
Kemps (sciatic) _____
Heel Walk (L5) _____
Toe Walk (S1) _____
Belt Test _____
Adams _____

THORACOLUMBAR ROM:

Flexion (110) _____
Thor (50) _____
Lumb (60) _____
Extension (25) _____
Lat Flexion (25)
Left _____
Right _____
Rotation (30)
Left _____
Right _____

SITTING EXAM

Minor's Sign (lumbar) _____
Cervical Compression _____
Cervical Distraction _____
Shoulder Depression _____
Spurling's _____
Naffziger _____
Bechterew's _____

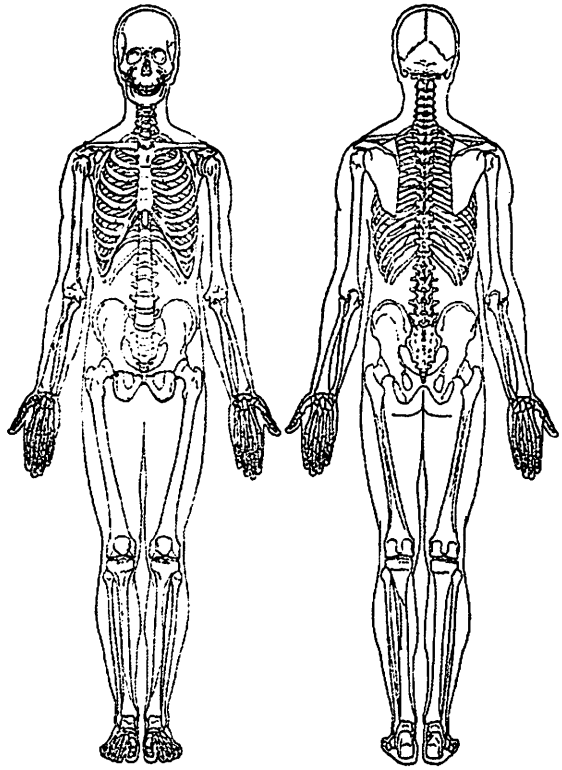
CERVICAL ROM:

Flexion (60) _____
Extension (75) _____
Lat. Flexion (45)
Left _____
Right _____
Rotation (80)
Left _____
Right _____

O'Donoghue's Maneuver _____
Adson's _____
Eden's _____
Wright's_____

CRANIAL NERVES (I-XII) □ WNL

_____
_____



MOTOR (0-5) □ WNL

Shoulder Elevation (CN XI, C3-C6	L__	R__
Shoulder Abduction (C4-C6)	L__	R__
Elbow Flexion (C5-C6)	L__	R__
Elbow Extension (C6-C8)	L__	R__
Wrist/Finger Flexion (C7-T1)	L__	R__
Wrist/Finger Extension (C6-C8)	L__	R__
Hip Flexion (L1-L3)	L__	R__
Knee Extension (L2-L4)	L__	R__
Knee Flexion (L4-S1)	L__	R__
Plantar Flexion (L5-S2)	L__	R__
Dorsiflexion (L4-L5)	L__	R__

PRONE EXAM

Spinous Percussion _____
Ely's Test _____
Hibbs Test _____
Nachlas Test _____
Deerfield Sign _____
Mennell's Test _____
Yeoman's_____

SUPINE EXAM

SLR _____ R _____ L _____
Braggard's _____
Lasague _____
Goldthwait (lumbosacral) _____
Kernig's Sign _____
Patrick Fabere _____
Soto-Hall _____
Lindner's _____
Millgram's _____

REFLEXES

Achilles (S1-S2)	Left	0 1 2 3
	Right	0 1 2 3
Patellar (L2-L4)	Left	0 1 2 3
	Right	0 1 2 3
Biceps (C5-C6)	Left	0 1 2 3
	Right	0 1 2 3
Triceps (C6-C7)	Left	0 1 2 3
	Right	0 1 2 3
Radial (C6-T1)..	Left	0 1 2 3
	Right	0 1 2 3
Umbilical (8-9-D).....		0 1 2 3

DYNAMOMETER

R___/___/___ L___/___/___

Patient is Right/Left handed.

MOTION PALPATION/COMMENTS

_____
_____
_____
_____
_____

4630 River Road N., Suite A ▪Keizer, OR 97303 ▪ (503)304-BACK (2225) ▪FAX (503-304-2226
Email: info@BACKtoHealthClinic.net ▪ www.BACKtoHealthClinic.net

BACK  to Health Clinic

Jeffery. W. Baker, DC.,PC- Cody A. Leder, DC- Alicia Jeffers, DC- Gideon Tarnasky, DC.

Informed Consent

The doctors and therapists at BACK to Health Clinic strive to provide treatments that offer a positive beneficial result. Our goal is to provide care that is both comfortable and effective. Treatments are generally very comfortable. If you develop questions, concerns or discomfort, please let us know so that we can help make your visit more enjoyable. Your communication will help us to provide you with an optimal positive experience.

Back to Health Clinic offers a variety of procedures, and since every patient's treatment is unique, your personalized treatment may include some or all of the following treatment procedures:

- Adjustments of the spine or extremities
- Heat pack application
- Massage therapy
- Spinal traction
- Ultrasound
- X-rays
- Nutritional counseling
- Paraffin wax or lotion application
- Laser
- Electrical stimulation modalities
- Gym exercise rehabilitation

WE BELIEVE ALL PROCEDURES WE PROVIDE TO BE SAFE AND EFFECTIVE. All medical procedures we provide may have inherent potential risks, but are extremely rare. However, allowing conditions to worsen when care is needed may be an even more serious risk to your health. We strive to take every precaution to provide quality care so that the benefits outweigh the risks. Complications may include soreness, skin discoloration, bone or soft tissue injury, neurological injury, allergic reaction to lotion, heat burn, neck or back pain, headache, or other unforeseen issues. Notify the care provider if you feel you may be experiencing any unusual symptoms so that the session can be modified for your comfort.

WE BELIEVE WE ARE THE TREATMENT OF CHOICE FOR MOST NERVE, MUSCULO-SKELETAL or PHYSICAL INJURY COMPLAINTS. Alternatives to chiropractic care may include home exercise, bed rest, stretching, weight control, physical therapy, and symptom control with acupuncture, homeopathic, or medicines. *(None of these options are without risk either).*

Please write any questions or concerns you wish to discuss before proceeding:

_____

_____

DO YOU ACCEPT TREATMENT? *(Initials)* _____ [YES] _____ [NO]

I have consulted with the care provider regarding any concerns or questions I have about the treatments and procedures offered. I have been informed of the risks and notified of alternative care options.

Minor Patient's Name: _____ Relationship to Minor: _____

_____ / _____ _____

Parent/Patient Signature & Printed Name Date

_____ _____

Doctor's Signature Date

4630 River Rd. N., Suite A
Keizer, OR 97303
Phone: 503-304-2225 Fax: 503-304-2226

BACK  to Health Clinic

Jeffery W. Baker, DC.,PC
Cody Leder, DC- Alicia Jeffers, DC- Gideon M. Tarnasky,DC

CONSENT TO TREAT A MINOR CHILD

I hereby authorize the doctors of BACK to Health Chiropractic of Oregon, and whomever they may designate as assistants to administer chiropractic care as they deem necessary to my _____(indicate relationship of child)

Name of child _____
Dated at _____, _____
City State
This_____ day of _____20____
Signed:_____
(parent or guardian)

Witnessed by: _____

CONSENT TO TRANSPORT A MINOR CHILD IN COMPANY VEHICLE

I hereby authorize the staff of BACK to Health Clinic, to transport my minor child, (child's name) _____ to and/or from their chiropractic and/or massage therapy appointments.
Name of child _____
Dated at _____, _____
City State
This_____ day of _____20____
Signed:_____
(parent or guardian)

Witnessed by: _____

4630 River RD, N., Suite A
Keizer, OR 97303
P#503-304-2225 F#503-304-2226

BACK to  Health Clinic

Jeffery W. Baker, DC., PC- Cody A. Leder, DC- Alicia Jeffers, DC- Gideon M. Tarnasky, DC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO BACK TO HEALTH CLINIC

NOTICE: Any information received pursuant to this consent may be used and disclosed for the purpose of Treatment, Payment, or Health Care operations. Patient has the right to review our privacy policy at any time, and may request in writing that the consent be revoked. Any information received and/or used prior to the written withdrawal of consent cannot be reversed. Patient also has the right to request restrictions of the medical information to be released.

I _____ consent to the release of all medical records in the possession of the medical facility listed below.

_____
_____
_____

You are hereby authorized to release a copy of the medical information for the following individual:

Patient Name: _____
Date of Birth: _____
Date of Injury (if applicable) ___/___/___

Permission is granted for the complete disclosure of all medical records, including examination findings, chart notes, lab results, x-ray films/reports, MRI/CT films/reports, diagnosis, treatment plan, and prognosis from ___/___/___ to current.

Permission is granted for the restricted disclosure of medical records, restrictions as follows:

_____
_____

Patient Signature:_____ Date:_____

Please send the requested medical records to the following address:

BACK to Health Clinic
4630 River Rd. N.
Keizer, OR 97303
Ph: 503-304-2225 Fax: 503-304-2226

Back to Health Clinic

4630 River Rd. N, Ste A
Keizer, OR 97303
P#503-304-2225 F#503-304-2226
Jeffery W. Baker, DC., PC- Cody A. Leder, DC- Alicia Jeffers, DC- Gideon M. Tarnasky, DC.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM BACK TO HEALTH CLINIC

NOTICE: Any information received pursuant to this consent may be used and disclosed for the purpose of Treatment, Payment or Health Care Operations. Patient has the right to review our privacy policy at any time, and may request in writing that the consent be revoked. Any information received and/or used prior to the written withdrawal of consent can not be reversed. Patient also has the right to request restrictions of the medical information to be released. If the patient refuses to sign the authorization, it will not affect condition treatment, enrollment, or eligibility of benefits.

Back to Health Clinic is hereby authorized to release a copy of the medical information for the following individual:

Patient Name: _____
Date of Birth: _____
Date of Injury (if applicable) ___/___/___

○ Permission is granted for the complete disclosure and re-disclosure of all medical records, including examination findings, chart notes, lab results, x-ray films/reports, MRI/CT films/reports, diagnosis, treatment plan, and prognosis from ___/___/___ to current.

○ Permission is granted for the restricted disclosure of medical records, restrictions as follows:

_____
_____

Please send these medical records to the following address:

Name:_____
Address:_____
_____
_____
Phone:_____ Fax: _____
Email records may be sent to _____

I, _____, consent to the release of all medical records in the possession of BACK to Health Clinic to the authorized entity.

Patient Signature:_____ Date:_____

BACK to Health Clinic

Electronic Health Records Intake Form

Jeffery. W. Baker, DC.,PC- Cody A. Leder, DC- Alicia Jeffers, DC- Gideon Tarnasky, DC.

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

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