Patient Registration Form

Date:________________

Patient Name:_________________________________ Date of Birth:_________________________

Preferred Name: ________________________ Marital Status: S M D W DP Sex: M / F

Address:____
Street City State Zip Code

Home Number:___________________________ Cell Number:___________________________

Email Address: ____

Occupation:__________________ Employer:________________ Work Number:_________________

Emergency Contact:________________________________ Phone Number:____________________

Insurance Information:

Your Private Health Insurance Company:______________________ ID#:______________________

Your Motor Vehicle Insurance Company:______________________ Claim#: ___________________

Your Worker's Compensation Carrier:_________________________ Claim#: ___________________

Date of Injury:__________________________

Primary Care Physician:_____________________________ Phone Number:___________________

May we contact your physician regarding your care here? ☐ Yes ☐ No

How were you referred to our office?

☐ Friend / Family Member:_________________________ ☐ Doctor:________________________

☐ Insurance Company:____________________________ ☐ Internet:_______________________

☐ Other:____

Patient Health Questionnaire

Name: ____ Date: ________________

- What is your **main area** of complaint?

  ____

- Please list ***ALL*** other areas of complaint:

  ____

- When did your symptoms with this episode start? (**Date Required**) _MM_/_DD_/_YY_
- Please describe the event/activity that led to your symptoms:

  ____

- Have your symptoms **improved**, **worsened**, or **stayed the same** since they began? **(circle one)**
- How often do you experience your symptoms?

  ① Constantly (76%-100% of the time) **② Frequently (51%-75% of the time)**

  ③ Occasionally (26%-50% of the time) **④ Intermittently (0%-25% of the time)**

- Describe your pain: **(circle all that apply)** Achy Sharp Stabbing Shooting Burning

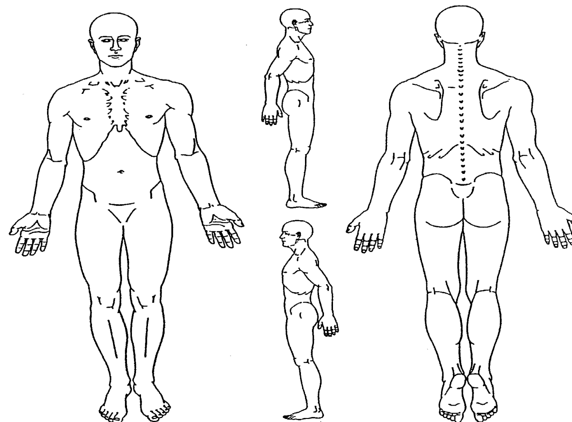
  Other: ____

- Pain intensity: **(circle)** Mild Moderate Severe Other: ____________________________

Average Pain Intensity:

Today:	**no pain**	0	1	2	3	4	5	6	7	8	9	10	**worst pain imaginable**
Last 24 hrs:	**no pain**	0	1	2	3	4	5	6	7	8	9	10	**worst pain imaginable**
Past Week:	**no pain**	0	1	2	3	4	5	6	7	8	9	10	**worst pain imaginable**

Indicate where you feel your symptoms with X's



- Do you have any headaches associated with your symptoms? (**circle one**) YES NO
- Do you have any of the following symptoms into either your arm(s) and/or leg(s)? (**circle all that apply**) Numbness Tingling Weakness Pain Other:__________________ None

- How much have your symptoms interfered with your usual daily activities?

  ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

- What makes your symptoms **WORSE**? ____
- What makes your symptoms **BETTER**? ____

- In general, how would you say your overall health is right now?

  ① Excellent ② Very good ③ Good ④ Fair ⑤ Poor

- Have you had any recent symptoms of (**circle all that apply**):
  Fever Fatigue Nausea Vomiting Diarrhea Loss of Appetite Malaise None

- Who have you seen for your symptoms? **① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Acupuncturist ⑥ Other: ______________**

- Have you received any treatments or medication? (**circle one**) YES NO

  If yes, what treatment(s) and/or medication(s)?

  ____

- Have you had any tests/imaging for your symptoms? (**circle one**) YES NO

  If yes, please circle all that apply and list the date the examination was performed:

  X-Ray date:__________ **MRI date:**__________ **CT scan date:**__________ **Other test date:**___________

Patient Signature: ____ **Date:** ______________________

Overall Health Status

Please **check all** of the following that apply to you:

☐ Abnormal Weight: Gain / Loss
☐ Allergies: ___________________
☐ Corticosteroids Used
(Cortisone, Prednisone, etc.)
☐ Currently Pregnant: weeks_____
☐ Diabetes
☐ Dizziness / Fainting
☐ Epilepsy / Seizures
☐ Heart Attack (date):__________

☐ High Blood Pressure
☐ Menstrual Problems
☐ Morning Pain / Stiffness
☐ Numbness in Groin / Buttocks
☐ Osteoporosis
☐ Pain at Night that awakens you from sleep
☐ Pain Unrelieved by Position or Rest

☐ Prostate Problems
☐ Recent Fever
☐ Stroke
(date):__________
☐ Taking Birth Control
☐ Tobacco Use
Type:___________
☐ Urinary Problems
☐ Visual Disturbances

☐ Cancer / Tumor (Explain): ____

☐ Surgeries: ____

☐ Medications: ____

☐ Serious Illnesses (Tuberculosis, Hepatitis, HIV, etc.): ______________________________________
☐ Other Health Problems (explain): ____

Family History: ☐ Heart Problems / Disease ☐ Cancer ☐ Diabetes
☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ Stroke

I certify to the best of my knowledge that the above information is complete and accurate. I agree to notify this office and my treating provider immediately whenever I have any changes in my health condition or health plan/insurance coverage in the future.

Patient Signature:________________________________ **Date:**______________________

Assignment of Benefits

This document is to serve as an Assignment of Benefits, allowing Milanovich Chiropractic LLC (DBA Milan Center) to bill your insurance, on your behalf, for charges that you incur here. Please remember, you are still responsible for any charges that you incur here until paid.

By signing this, you authorize payment of your insurance benefits directly to the provider, or Milanovich Chiropractic LLC (DBA Milan Center) or our respective agent(s). You also authorize this office to release and communicate all information necessary to assist with the processing and paying of your claim(s) with your insurance company or other collection agency, personal physician or other healthcare provider(s).

It is our standard office policy to not bill your insurance carrier unless this Assignment of Benefits has been agreed to and signed by you. If you are unwilling to agree to this Assignment of Benefits, it is our standard office policy to collect for the entire visit's charges at the time of service.

Your signature below indicates that you have read and accepted this Assignment of Benefits.

Signature: ________________________________ **Date: ___________________**

Quote of Insurance Benefits

At Milan Center, we do our best to verify your insurance and get a quote of your benefits for you from your insurance company. Unfortunately, as your insurance company states, "a quote of benefits is not a guarantee or acceptance of payment."

With continued changes to healthcare laws and benefits, it is becoming increasingly more difficult to accurately assess your benefits and estimate your responsibility of payment. We provide services including examinations, chiropractic manipulations, physical therapy and modalities as well as massage therapy. These services are now typically falling into their respective categories for payment, whereas in the past all services provided by a chiropractor fell exclusively under your chiropractic benefit plan. We are not able to fully assess which category of benefits your insurance company will process each service under. You may see that within the same office visit some benefits/services will apply to your deductible while others may have a copay or coinsurance percentage. Ultimately it is your responsibility to understand your individual benefits. _____ **(initial)**

We will attempt to bill your insurance for you. You will receive an EOP (explanation of payment) from your insurance company advising you of what was billed, paid for and what portion is your responsibility. Monthly statements will be mailed to you from us after we have received the EOP from your insurance company detailing any additional payment that is due from you.

We do our best to give you an estimated quote at the time of service. We will collect your estimated deductible, coinsurance and/or copay at the time of service but be aware that this may not cover your entire financial responsibilities due for the services you receive at this clinic.

Signature: ___________________________________ **Date:** _______________

Financial Policy

By signing this document, you the patient, understand and agree that your health/accident insurance policy(s) represent an arrangement between you and an insurance carrier(s). You are responsible to uphold your contractual obligation with your insurance carrier(s) if you want them to pay for services on your behalf. We may help to clarify or explain some of the points of typical insurance benefits and/or payment options, but **you are responsible for your individual situation. This likely requires that you have fully reviewed your insurance policy. _________ (initial)**

By signing this document, you also understand and agree that you are responsible for the timely payment of the charges that you incur here. Per your insurance contractual obligation, you may be responsible to pay a Co-Pay, Co-Insurance, Deductible or other fees as well as to cooperate with your insurance carrier(s) with additional paperwork or correspondence to assist them in assessing and managing your claim(s).

The following are general definitions of three commonly used terms associated with insurance:

> Co-Pay: A fixed amount that you pay per your insurance plan for each visit that you seek with a provider. A Co-Pay is due at the time of service.
>
> Co-Insurance: A percentage that you pay (Example: 20% or 30%) per your insurance plan, based on the insurance carrier(s) accepted claim(s) information. Your Co-Insurance becomes due and payable upon the processing of the claim from your insurance carrier.
>
> Deductible: A fixed dollar amount per your insurance plan that you are responsible to pay. Your insurance begins to pay for the accepted claim(s) after your deductible has been met.

We will typically call to verify your insurance coverage for the services that you receive here. However, as most insurance carriers' state on the recording: **"A quote of benefits DOES NOT GUARANTEE that those services will be accepted or paid for." If services are not accepted and/or paid for, on your behalf, you may be required to pay for them. _________ (initial)**

Our Standard Office Fee Schedule is based on the State of Oregon's Worker's Compensation Fee Schedule. You may request and obtain a written copy of our standard fee schedule if you would like.

If you do not have insurance with coverage for any and/or all of the services that you receive here or do not want to assign your insurance benefit(s), it is our standard office policy that you will be required to pay for all services at the time of your visit.

If you accrue a balance with us and it is deemed by us to be delinquent, we may utilize a Collection Agency or similar, to assist in the collection of your account. This may involve referring your account to a major Credit Reporting Agency and may affect your credit rating or score.

Signature: ____________________________________ Date: ________________________

Authorization For Treatment

By my signature below I am authorizing treatment to be rendered and that I understand the risks and alternatives listed below. I also understand that if a treatment plan is prescribed for me, I have the responsibility to follow through with scheduled appointments and recommendations.

This office utilizes chiropractic, physical therapy, and massage therapy as conservative forms of health care with the use of manipulation, manual therapy, exercise, and in many cases physiotherapy modalities among other treatment. A history and examination and X-rays or other tests (if indicated) are performed before or during treatment to minimize potential risk factors to treatment and to make sure that this type of care is appropriate for your condition.

Potential risks and their probability of occurrence may include:

- Soreness following treatment is fairly common. This is usually mild in nature and is alleviated by the use of ice and/or heat. This is usually not an issue as treatment progresses.
- Mild burns due to physiotherapy have a rare occurrence and you should seek assistance if the therapy is uncomfortable to avoid this potential problem.
- Fracture has a very rare potential risk and is screened for in the initial history and examination. Light force or non-force techniques are used on individuals at risk (like people with osteoporosis).
- Herniated disk has an extremely rare occurrence and usually occurs with very high force techniques.
- Stroke and/or death have an extremely rare occurrence. The manipulation posing the most risk is not performed in this office.

On a statistical basis, the majority of our patients report improvement with treatment. Some describe no change and some describe an increase in signs or symptoms with treatment. Every effort will be made to screen out those for whom treatment will not be helpful so that the potential for success will be higher.

Alternatives for care include:

- Allopathic or conventional medicine which may include the use of pharmaceuticals and/or surgery.
- Physical therapy, chiropractic, and massage therapy services which are available at this office.
- Alternative disciplines of many kinds that should be undertaken with your own research.
- Doing nothing. Your symptoms may go away on their own, but underlying conditions may worsen or potentially serious problems may go undetected.

I have read the above text and understand its meaning. No financial commitment is made by signing this form.

Signature: ____ **Date:** ____________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Milanovich Chiropractic LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Milanovich Chiropractic LLC."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Milanovich Chiropractic LLC to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership
In the event that Milanovich Chiropractic LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Milanovich Chiropractic LLC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Milanovich Chiropractic LLC amend your protected health information. Please be advised, however, that Milanovich Chiropractic LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Milanovich Chiropractic LLC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Milanovich Chiropractic LLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Milanovich Chiropractic LLC is required by law to comply with this Notice.

Milanovich Chiropractic LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Michael Milanovich or Dr. Peter Milanovich by calling the office at 503.635.6005. If either doctor is not available, you may make an appointment for a personal conference in person or by telephone.

Complaints
Complaints about your Privacy rights, or how Milanovich Chiropractic LLC has handled your health information should be directed to Dr. Michael Milanovich or Dr. Peter Milanovich, by calling this office at 503.635.6005. If either doctor is not available, you may make an appointment for a personal conference in person or by telephone.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

______________________________________	____________________
Signature	Date
______________________________________	____________________
Witness	Date