

## Optimum Function Patient Checklist:

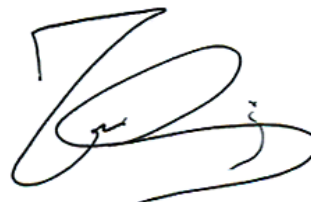
### DID YOU REMEMBER TO?

- Read all of the documents

### FILL OUT AND/OR SIGN THE FOLLOWING FORMS

- Patient Acceptance Policy
- Authorization for Release of Medical Information
  - o **\*\* Only if you have pertinent medical records that need to be retrieved; if you are not sure, skip this step\*\***
- Establishing Your Health Goals
- Chiropractic Patient Intake Form
- Financial Policy
- Informed Consent
  - o **\*\*Please keep a copy of this for your own records. I will go over this form during our first appointment\*\***
- When all of these forms are completed, feel free to return them to me before your initial visit by faxing them to 503-716-4575 or scanning and emailing them to forms@OptFunction.com

Yours in Health



DC, L.M.T

Dr. Tim Irving DC, LMT, Nutritionist  
819 SE Morrison St., Suite 215  
Portland, Oregon, 97214

## Frequently Asked Questions:

### ***Do you think you can help me reach optimum function?***

I use an innovative approach to assessing and treating your health care concerns. Perhaps you have experienced being examined by your doctor or chiropractor only to be sent home with some medication or “popped” “cracked” and sent home. If you have then maybe this type of treatment left you wanting more; at Optimum Function, you get more.

Most physicians are trained to look in very specific places for the answers, using the tests and procedures that limit their ability to put together your specific health story. The usual tests do not look for functional disturbances, the involvement of many muscles, muscle groups and joints and how your diet and lifestyle plays a role in your current health status. I have been treated by doctors like this and my treatment did not satisfy my needs. This is why I promise to look deeper into your current health concerns than your average chiropractor.

I use a variety of innovative testing techniques and procedures to help my patients prevent injury, illness and recover from many chronic and difficult to treat conditions and achieve optimal function.


### ***Do you take insurance?***

I do not accept Medicare but will attempt to bill your insurance company if you have “out of network” coverage that will reimburse me for the work I will do with you or if you have Blue Cross/Blue Shield or ODS. Some insurance carriers may partially cover the services and tests performed by me. Payment in full by check, cash or credit card is due at the time services are provided unless we are going to attempt to bill your insurance, then you will be responsible for anything the insurance company does not pay for.

### ***What credit cards do you accept?***

I accept the following credit cards: MasterCard, Visa and Discover. If you like, I can maintain an active credit card on file at the office so I can bill follow-up consultations, laboratory testing, and other services with your approval.

Yours in Health,



D.C., L.M.T

Dr. Tim Irving DC, LMT, Nutritionist

## Patient Acceptance Policy

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. It is my opinion that you should be well informed on our expectations and clinical procedures. To prevent any misunderstandings or confusion on what to expect, I need you read the steps below and provide your signature. This would simply imply that you have read the *Patient Acceptance Policy* and understand what is expected of you.

**1. Completion of the required forms:**

- It is **VERY** important for you to carefully and thoroughly complete all of these forms and questionnaires prior to our first appointment. In many cases, I will wait to schedule your first appointment until I received all of the necessary paperwork/medical records so I can have a clear picture of your health up until you came to Optimum Function.

**2. Medical Records: if you have medical records that are pertinent to the reason you are coming to see me please bring them with you.**

3. The cost of your initial appointment is included in the price of the program you have enrolled in. When medically necessary, I may require that you participate in tests not included in the program you have chosen. This is for your own health and well-being, there is no way to predict when this is necessary and if this situation occurs, I will disclose all of the reasons and all of your options to you so you can make an educated decision.


4. Your treatment may consist of any combination or individual treatment as listed: chiropractic manipulation, therapeutic soft-tissue work, Graston Therapy, Kinesiotaping, therapeutic exercise, hot/cold therapy, vibration assisted massage, low level laser therapy, dietary and lifestyle changes. When necessary, I may recommend prescribed **Natural Pharmaceuticals**, which will be custom ordered for you and must be paid for at the time they are ordered or received.

5. It is strongly recommended that you have access to a computer with Internet Connection. **Support forms, and information will be sent to you via email.** Other forms may be periodically sent to you to monitor your progress. Correspondence by e-mail is strongly encouraged and is **Free of Charge**.

6. Follow-up treatments and exams will be scheduled as needed and as I feel your specific health goals warrant. I will come up with a working treatment plan based on the findings in this initial history-taking and examination. Your cooperation in taking "**personal responsibility**" in your health care and following my treatment plan is necessary to help you achieve optimal health and optimum function.

7. **If, in the course of your initial history and physical examination I feel that you would be better served by another health care provider, I will explain why and give you a referral.**

I, \_\_\_\_\_ (print your name) have read and fully understand the **Patient Acceptance Policy**



DC, L.M.T

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr. Tim Irving DC, LMT

## REQUEST FOR MEDICAL RECORDS

**PURPOSE OF REQUEST:** For diagnostic assessment and to complete medical records **DATE:** \_\_\_\_\_

Patient Name (Print):	
Patient Identification:	<b>Address:</b>  <b>Phone Number:</b>  <b>Social Security No:</b> _____ <b>Date of Birth:</b> _____

**Name and address of Doctor/Facility where patient's medical records are located:**

Name:	
Address:	
Phone/Fax	

**WHAT MEDICAL RECORDS ARE AUTHORIZED TO DISCLOSE AND MAIL:**

<input type="checkbox"/> All Medical Records: _____ <input type="checkbox"/> X-Ray/MRI/CT reports/films (circle): _____ <input type="checkbox"/> Lab work (CBC, chem. screen): _____ <input type="checkbox"/> IME or consulting reports dated: _____ <input type="checkbox"/> Other _____ Dated: _____
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**SEND THE SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:**

**Optimum Function  
 Dr. Tim Irving DC, LMT  
 819 SE Morrison St. Suite 215  
 Portland, OR, 97214  
 Ph.503.866.9739  
 Fax.503.716.4575**

I, (Patient Print Your Name) \_\_\_\_\_, hereby request and authorize disclosure of information in the above medical records to be photocopied, released and mailed to above doctor at the indicated address for the specified dates. The information obtained with this form will be used to assist the named chiropractor in determining the nature of the specified patient's prior medical condition(s) and/or injuries and what testing, diagnosis, or treatment was provided as well as other relevant information. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days if kept on-site, and 60 days if stored off-site, once this request has been received. This authorization may be revoked by me, at any time, by advising the doctor's office (privacy officer) of this revocation in writing, except to the extent a source of information has already relied on it. I have been advised that if I choose to not sign this authorization that it will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payment.

**EXPIRES:** This authorization is good for 12 months from the date signed for the disclosure of the information described above.

**Individual Authorizing Disclosure:** \_\_\_\_\_ / \_\_\_\_\_  
*Signature* **Date**

If not signed by subject of disclosure, specify basis for authority to sign:  Parent of minor  Guardian

This general and specific authorization to disclose was developed to comply with the provisions regarding disclosure of medical information under HIPAA: 45 CFR parts 160 and 164, 42 CFR part 2, 38 CFR, 34 CFR parts 99 and 300, and State law.

# Establishing Your Health Goals

Name \_\_\_\_\_ Date \_\_\_\_\_

## Personal Message Before You Begin

Before you begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality; a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

**What do you hope to achieve in your visits with me?**

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**If you had a magic wand and could erase three problems, what would they be?**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Have you made the decision to change? To do what it takes to get well?**

Yes \_\_\_\_\_ No \_\_\_\_\_

I have read something interesting: ***"The definition of insanity is to keep doing the same thing and expecting different results"***. If you keep following the same course of treatment, your results may never really change. Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they're made the decision to change. Very few people have truly decided to change. Why? Because there is a big difference between deciding something and having "reasons" to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

**2. List up to 5 things that you have been unable to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)**

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**3. List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)**

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**4. Please check off the following that you would like to achieve with my help:**

<ul style="list-style-type: none"><li><input type="checkbox"/> Have more energy</li><li><input type="checkbox"/> Sleep better</li><li><input type="checkbox"/> Have better digestion</li><li><input type="checkbox"/> Be able to work out again</li><li><input type="checkbox"/> Have better muscle tone</li><li><input type="checkbox"/> Be in less pain</li><li><input type="checkbox"/> No longer use pain medication</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> To feel less sleepy in the afternoon</li><li><input type="checkbox"/> Lose weight</li><li><input type="checkbox"/> Increase my sex drive</li><li><input type="checkbox"/> Increase my metabolism to burn more fat</li><li><input type="checkbox"/> Increase my flexibility I want to reduce my stress</li><li><input type="checkbox"/> I want a better mood</li><li><input type="checkbox"/> I want to reduce my risk of developing a chronic disease</li></ul>
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**5. Are there any other health goals you want to achieve?**

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# CHIROPRACTIC PATIENT INTAKE FORM

Today's Date: \_\_\_\_\_

<b>Last Name:</b>		<b>Middle:</b>	<b>First Name:</b>	
<b>Home Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>
Date Birth:	Age:	Height:	Weight:	
Who Referred You to Our Office:		Marital Status (Circle): Single, Married, Divorced, Widowed		
Occupation:		Family/primary physician:		
Employer's Name:		Phone number and/or address of physician:		
Hobbies:				

<p><input type="checkbox"/> <b>YES</b>, <input type="checkbox"/> <b>NO</b> I authorize the following telephone numbers</p> <p><input type="checkbox"/> <b>YES</b>, <input type="checkbox"/> <b>NO</b> I authorize the use of my address for mailing</p> <p><input type="checkbox"/> <b>YES</b>, <input type="checkbox"/> <b>NO</b> I authorize the use of my email address for announcements and newsletters</p> <p><input type="checkbox"/> <b>YES</b>, <input type="checkbox"/> <b>NO</b> I authorize Optimum Function to contact the necessary health care providers to obtain pertinent health information.</p> <p><b>Email and Phone Numbers:</b></p> <p>Email: _____ Home Ph: _____</p> <p>Cell: _____ Work _____</p> <p>Indicate if you have a preferred mailing address:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Signature: _____ Date: _____</p>	<p>Our office needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State Health Insurance Portability and Accountability Act (HIPAA) patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call.</p> <p>Your agreement will allow our office to use your name, email address and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements or questions, status of your account, and other office related matters.</p> <p>We will use your email address home address, noted to the left, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising Dr. Irving of this revocation in writing or email.</p>
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<b>THIS VISIT IS RELATED TO:</b>		
<input type="checkbox"/> Work Related Injury/Symptoms <input type="checkbox"/> Sport or Recreational Injury <input type="checkbox"/> Motor Vehicle Crash Injury	<input type="checkbox"/> Motorcycle-Bicycle Injury <input type="checkbox"/> Home Injury Symptoms <input type="checkbox"/> School/Employment Physical	<input type="checkbox"/> Non-Injury Pain/Symptoms <input type="checkbox"/> Check-up Only <input type="checkbox"/> Other (Describe):

**Emergency Contact:** Name \_\_\_\_\_ Phone \_\_\_\_\_

**Our office will attempt to provide Insurance Billing Services as a courtesy. We require the co-payment and/or deductible for health insurance payments and for patients who do not have insurance or choose not to bill their insurance, payment at the conclusion of each treatment.**

Patient Signature and Date	I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health/automobile insurance carrier. Minors must have parent's signature.
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# PATIENT HEALTH HISTORY (Page 1)

## LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, or Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, or Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, or Tingling		<input type="checkbox"/> Shoulder pain	
<input type="checkbox"/> Knee pain		<input type="checkbox"/> Elbow/wrist pain	
<input type="checkbox"/> Ankle pain		<input type="checkbox"/> Fatigue	
<input type="checkbox"/> Abdominal pain/cramping		<input type="checkbox"/> Exercise intolerance	
<input type="checkbox"/> Shortness of breath		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

**Did your current symptoms come on?**  Suddenly,  Gradually

### SYMPTOM/PAIN DESCRIPTION

*Please check the box near any word or all words below that best describes how your symptoms currently feel to you.*

<input type="checkbox"/> Pain	<input type="checkbox"/> Pinching	<input type="checkbox"/> Spreading	<input type="checkbox"/> Sickening	<input type="checkbox"/> Unbearable
<input type="checkbox"/> Ache	<input type="checkbox"/> Pricking	<input type="checkbox"/> Shooting	<input type="checkbox"/> Miserable	<input type="checkbox"/> Soreness
<input type="checkbox"/> Cutting	<input type="checkbox"/> Tingling	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Troublesome	<input type="checkbox"/> Pins and Needles
<input type="checkbox"/> Tearing	<input type="checkbox"/> Gnawing	<input type="checkbox"/> Dull	<input type="checkbox"/> Pressing	<input type="checkbox"/> Radiating
<input type="checkbox"/> Crushing	<input type="checkbox"/> Nagging	<input type="checkbox"/> Bony	<input type="checkbox"/> Deep pain	<input type="checkbox"/> Weakness
<input type="checkbox"/> Pulling	<input type="checkbox"/> Boring	<input type="checkbox"/> Terrifying	<input type="checkbox"/> Superficial pain	<input type="checkbox"/> Falls asleep
<input type="checkbox"/> Irritating	<input type="checkbox"/> Burning-Hot	<input type="checkbox"/> Dreadful	<input type="checkbox"/> Stinging	<input type="checkbox"/> Suffocating
<input type="checkbox"/> Annoying	<input type="checkbox"/> Drill like	<input type="checkbox"/> Fearful	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Crawling
<input type="checkbox"/> Stiff or tight	<input type="checkbox"/> Heavy	<input type="checkbox"/> Unhappy	<input type="checkbox"/> Sharp	<input type="checkbox"/> Tender
<input type="checkbox"/> Exhausting	<input type="checkbox"/> Numbness	<input type="checkbox"/> Torturing		

No,  Yes Do you have any problems laying face down on an examination table?

If yes, why: \_\_\_\_\_

### HISTORY OF PRESENT COMPLAINT:

When did your problem begin? \_\_\_\_\_

#### How did your problem begin?

No apparent reason     Bending     Lifting     Fall

Motor Vehicle Collision     Other \_\_\_\_\_

Have you had a similar episode before?  Yes  No

What have you been told is wrong? \_\_\_\_\_

\_\_\_\_\_

#### **Prior tests for your problem:** I have had no tests for this problem

Test/Results:

X-ray \_\_\_\_\_

MRI \_\_\_\_\_

CT \_\_\_\_\_

Lab \_\_\_\_\_

Other \_\_\_\_\_

#### Anything Else You Would Like to Tell

#### Me About Your Present Complaint:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# PATIENT HEALTH HISTORY (Page 2)

## HISTORY OF PRESENT COMPLAINT continued:

**Treatment for your current problem:**

I have had no treatment for this problem

**I have been prescribed:**

- Anti-inflammatory medication,  
 Muscle Relaxers,       Pain medication  
 Other \_\_\_\_\_ Results: \_\_\_\_\_

Steroids:  Cortisone pills       Cortisone injection

Other \_\_\_\_\_ Results: \_\_\_\_\_

Injections:                       Epidural    Facet    Other  
 Results: \_\_\_\_\_

- Spinal surgery: Year/Procedures/Results \_\_\_\_\_  
 Physical therapy: Year/Procedures/Results \_\_\_\_\_  
 Chiropractic: Year/Procedures/Results \_\_\_\_\_  
 Other Treatments: Year/Type/Results \_\_\_\_\_

**Has your problem:**    Improved    Worsened    Not changed  
**Is your problem:**     Constant      Intermittent

**How do the following affect your problem?**

	Worse	Better	No change
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At the end of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
While sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough/sneeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting to Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List daily activities and/or specific movements that help/hurt your primary complaint: \_\_\_\_\_

Optimum Function Initial Health Intake Form

**Anything Else You'd Like to Tell Me About Your Current Problem:**

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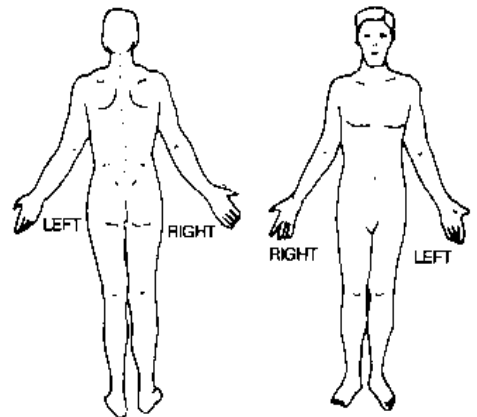
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Please fill out the pain drawing below

Use these symbols on the drawings:

- >>>> Ache                      □□□□ Numbness  
 X X X X Burning                0 0 0 0 Pins and Needles  
 ////////////// Stabbing



**What level would you rate your pain right now?**

(please circle)

None 0 1 2 3 4 5 6 7 8 9 10 Most severe

## PATIENT HEALTH HISTORY (Page 3)

### HAS YOUR PROBLEM BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Kidney pain/painful urination
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Balance problems

### PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PROBLEMS

**( I have no history of previous painful injury or problems)** If you have had prior injuries or pain, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car Accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Arm numb-tingling	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Leg pain-numb-tingling	<input type="checkbox"/> Other Pain:	

### FRACTURES/BROKEN BONES HISTORY

**( I have never had any broken bones).** If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Rib bone	
<input type="checkbox"/> Arm or hand bones		<input type="checkbox"/> Leg or foot bones	
<input type="checkbox"/> Pelvis or hip bones		<input type="checkbox"/> Other: List	

### PREVIOUS SURGERIES

**( I have never had any surgical procedure).** If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck, back, or pelvis)		<input type="checkbox"/> Appendix or stomach	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Head/Brain		<input type="checkbox"/> Hernia (inguinal or hiatal)	
<input type="checkbox"/> Shoulder/Arm/Hip/Leg		<input type="checkbox"/> Other	

### Have you ever been to a Chiropractor before for any other condition?

No,  Yes    If yes, Chiropractor's Name : \_\_\_\_\_ Year: \_\_\_\_\_  
 Problem(s) seen by Chiropractor for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### ARE YOU TAKING ANY MEDICATIONS?

**I am not taking any medications currently.** Check any of the following that you are taking currently.

<input type="checkbox"/> NSAIDS (Ibuprofen etc.)	<input type="checkbox"/> Blood pressure/Stroke prevention medications	<input type="checkbox"/> Acid reducers
<input type="checkbox"/> Diuretics	<input type="checkbox"/> Osteoporosis (bone strengthening) medications	<input type="checkbox"/> Blood Thinners (coumadin/warfarin)
<input type="checkbox"/> Birth control	<input type="checkbox"/> Hormone replacement	<input type="checkbox"/> Other:

### Anything Else You'd Like to Tell Me About Your Past Health History:

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## **Optimum Function's Financial Policy**

Thank you for choosing Optimum Function as your health care provider for chiropractic, functional movement and manual medicine. I am committed to the success of your treatment. The following is a statement of my Financial Policy, which I require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with me promptly and frankly. I will make every effort to avoid a misunderstanding or rectify an injustice.

### **PAYMENT AT TIME OF SERVICE**

Payments may be made by cash, check, Visa, MasterCard, American Express, Discover or debit card. By paying at time of service, costly book-keeping, accountancy and billing expenses have been eliminated. However, this discount is only valid when payment for services rendered is received on the day of service. If any billing is to occur (insurance or the patient) then you will be billed at my billable office rates.

### **INSURANCE**

As a courtesy to you, I may bill your insurance carrier for you. All co-payments, deductibles, and payments for supplements, supports, and other "non-covered" services are due at time of service unless prior arrangements have been made. Payments may be made by cash, check, Visa, MasterCard, American Express, Discover or debit card. Any unpaid balances 60 days and over will be charged interest of 2.0% per month. If you are unable to pay in full, it is your responsibility to contact me to set up an agreeable payment plan. Each patient's insurance policy is a contract between the patient and their insurance company. I am not a party to that contract.

### **UCR (USUAL AND CUSTOMARY RATES)**

My practice is committed to providing the best treatment possible for my patients, and I charge what is usual and customary for my area and expertise. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

### **INJURIES/ACCIDENTS INVOLVING LITIGATION**

I will make every effort to recover my fees from all available sources, including your health insurance and any med-pay benefits that are available on your auto insurance policy. It must be understood, however, that payment of the balance is ultimately your responsibility.

**WORKER'S COMPENSATION**

If I have accepted a worker's compensation case, I will file your claims. It is your responsibility to contact your employer to establish a worker's compensation claim. If the claim is denied, I will bill your personal health insurance carrier if applicable. If the claim is unsettled or unpaid within 90 days, you will receive a statement from me.

**MOTOR VEHICLE COLLISIONS**

In the state of Oregon motor vehicle collision (MVC) cases are billed to your auto insurance company. A MVC claim and appropriate paperwork must be filed with your insurance company prior to treatment. The insurance company may not cover 100% of the bill and you are responsible for the difference.

**MINORS**

An adult must accompany the minor at the time of the first visit. The adult accompanying the minor is responsible for payment of the account.

**MEDICARE/MEDICAL ASSISTANCE PARTICIPANTS**

I do not accept Medicare or Medicaid assignment.

**MISSED APPOINTMENTS**

I require 24 hours notice for cancellation of all appointments. There will be a \$35.00 charge to the patient for all appointments that are missed and not canceled 24 hours or more before your scheduled appointment time.

**PATIENT'S STATEMENT:**

I have read and I understand the Financial Policy of Optimum Function. I understand that I am ultimately responsible for the payment of any services or products received at this office. I also understand that I will be responsible for any fees related to collecting my unpaid balance, including reasonable attorney fees.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
(Parent or Guardian if patient is under 18 years of age)

Patient's Name  
(printed): \_\_\_\_\_

## Informed Consent:

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself, (or on the patient named below, for whom I am legally responsible) by **Dr. Tim Irving, DC, LMT**, and/or other licensed doctors of chiropractic who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for **Dr. Irving**, whether or not their names are listed on this form.

I understand and consent to the following procedures: examination, x-rays, in-office or out-of-office lab work or other diagnostic measures (if needed), neck and spine/extremity adjustments, joint mobilization, soft-tissue therapies (specifically: Graston, G5 percussion/vibration therapy and Kinesiotape), hot/cold therapies, traction, and/or other procedures recommended for my condition(s).

I have had an opportunity to discuss with **Dr. Irving**, the various types of treatment, including Graston, other soft-tissue techniques and spinal adjustments, which have been proposed to me for my condition, and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I have been informed about the risks and benefits of chiropractic adjustments and other procedures performed at **Optimum Function**, and understand that, there are some rare, but potential risks to chiropractic adjustments and procedures, including, but not limited to, mild to moderate bruising, sprains, fractures (most commonly ribs), disc injuries, dislocations, nerve injuries, and strokes specifically from neck adjustments. I understand and have had the opportunity to ask about risks and benefits the proposed treatment and of other alternative types of treatment for my condition.

I have had the opportunity to read this form understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

**Patient Name (Print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**X** \_\_\_\_\_

**Signature of Patient or Responsible Party**

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor):