Therapia
WELLNESS CLINIC

2505 SW Spring Garden St, Ste. 100
Portland, OR 97219
phone: (503) 841-6222
fax: (503) 841-6199
email: info@therapiaclinic.com
web: TherapiaClinic.com

CANCELLATION POLICY

In order to provide quality care for all of our patients, we try to maintain an efficient appointment system. Due to our often fully booked schedule, other patients' care and our providers' ability to treat is greatly impacted when patients fail to keep scheduled appointments. **Appointments are reserved exclusively for you -- a scheduled appointment is a commitment between you and our practice.**

By signing this document, you acknowledge and agree to the following stipulations:

We require at least **24 hours** notice for any canceled or rescheduled appointment. We will charge and collect ***$50 for each*** appointment canceled or rescheduled within less than 24 hours, and we reserve the right to charge up to the full amount. We do charge the full prompt pay price for no shows.

We strive to provide reminder calls one business day before your scheduled appointment, but **these reminder calls are a courtesy.** If we are unable to provide you with a call or we reach you less than 24 hours before your appointment, the 24-hour policy still applies.

If the cancellation policy is broken by a patient multiple times, we reserve the right to charge the full prompt pay price for future missed appointments in lieu of the $50 fee amount. We also reserve the right to refrain from scheduling you until all outstanding fees are paid.

These fees will begin to accrue the same 4% compounded monthly interest rate 30 days after the missed appointment, congruent with other outstanding balances with our clinic.

We understand that events come up that are out of your control. However, in order to provide quality treatment for all patients and ensure that our practitioners utilize their valuable time, there are no exceptions to this policy.

We sincerely appreciate your understanding and cooperation.

Patient or Responsible Party Name: _____

Signature of Patient or Responsible Party: _____

Date: _____

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INFORMED CONSENT FOR CHIROPRACTIC SERVICES

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

These complications include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are rare. Additional information on side effects is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient Name: _____ DOB: _____ / _____ / _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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

Therapia P.C. 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.

We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

As our patient, you have important rights relating to inspection and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. You have the right to a paper copy of this Notice of Privacy Practices at any time upon request. We reserve the right to amend or revise this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

_____ Patient Signature/Parent or Guardian Date

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Financial Agreement For Health Insurance

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage
Many insurance policies do cover acupuncture and alternative healthcare, but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for alternative healthcare. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductible, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage and will bill your insurance in a timely manner.

Payment Arrangements
We require that you pay your co-payment or time of service amount at the time of your treatment. Your full portion of the bill is expected to be when payment is received from your insurance carrier. Any unpaid balances will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 4% applied per month.

Assigned Arrangements
By signing this form, you are authorizing payment of medical benefits that will be made directly to this office. If your insurance carrier sends payment to you for the services incurred in this office, you agree to send or bring those payments to this office upon receipt. However, if you pay for your visits in full, the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information
By signing this form you are also authorizing this office upon request from your insurance carrier for the release of any medical or other information necessary to process the claim. You acknowledge and request payment of government benefits either to myself or to the party who accepts the assignment, namely this office.

We hope this answers any questions you might have concerning the financial policy of this office. Once again, we welcome you to our office and will be glad to answer any further questions that you might have.

I have read and agree to the above.

_____ _____
Patient Signature/Parent or Guardian **Date**

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Patient Data:

Legal First & Last Name: _____ Name preferred: _____

Phone number:(_____)_____-_____ Email address: _____

Date of Birth: ____/____/ _____ Age: _____ Assigned sex: ▫ M ▫ F Preferred Pronouns: ▫She/Her▫ He/Him▫ They/Them

Mailing Address: Street _____ City _____ State _____ Zip Code: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: (_____)_____-_____

How did you hear about us? (If someone referred you, who?) _____

Occupation? _____ Employer? _____. How sedentary is your job: ▫ Very. ▫ Hardly ▫ Mix

Previous Care Experience:

Have you ever had ACUPUNCTURE before? ▫ No. ▫ Yes, when?_____

Have you ever had CHIROPRACTIC care before? ▫ No. ▫ Yes, when?_____

Have you ever had a professional MASSAGE or bodywork treatment? ▫ No. ▫ Yes, when?_____

Do you have any questions about any of the treatments above or notes about previous experiences you would like to add?

_____

Medical History:

When was the last time you saw your Primary Care Doctor? _____

Are there any past or current health conditions? ▫ No. ▫ Yes, explain:_____

Have you had any x-rays taken in the last year? ▫ No. ▫ Yes, when, area taken, results?_____

Have you ever broken a bone? ▫ No. ▫ Yes: When and what bone (right or left)? _____

Have you ever been in an auto accident? ▫ No. ▫ Yes, when? _____

Have you ever had surgery or been hospitalized: ▫ No. ▫ Yes, when and what for: _____

Is there a chance you might be pregnant? ▫ No. ▫ Yes, how far along?_____

Any allergies? ▫ No. ▫ Yes, explain: _____

What medications are you currently taken (please list name & what it is for):

_____

What supplements/vitamins are you currently taking? _____

Are you interested in Chinese Herbs? ▫ No ▫ Yes ▫ Not sure _____

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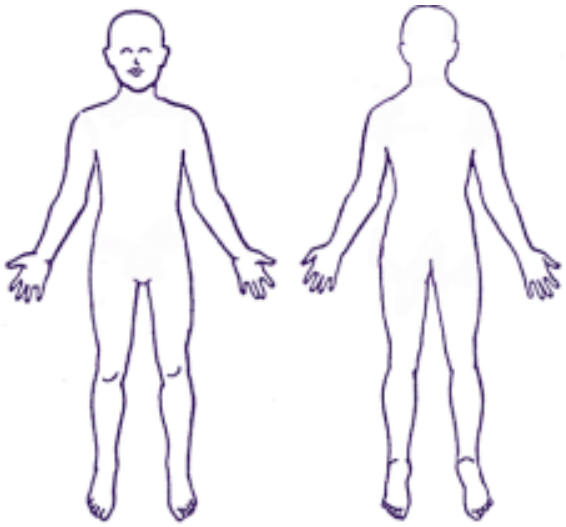
Family History: *Please select if any immediate family members has/had any of the following:*

▫ Diabetes ▫ Hypertension/High blood pressure ▫ Heart Disease ▫ Cancer ▫ Arthritis ▫ Thyroid Disorder ▫Mental health disorder ▫ Stroke ▫ Seizure ▫ Other: _____

Primary Complaint(s): _____

Have you had this pain before? ▫ No. ▫ Yes.



On the diagram, please mark the following and use the symbols to explain what it feels like in each area:

ACHE >>>> BURNING XXXX NUMBNESS ==== STABBING //// PINS/NEEDLES 0000 THROBBING ~~~~

When did the pain/discomfort start? _____

How frequent are your symptoms present?

▫ 0-25% ▫ 26-50% ▫ 51-75% ▫ 76-100%

Where would you rate your symptoms today?

0= no pain; 10 = worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

In the past week, how much has your pain interfered with your daily activities? 0= no interference; 10 = unable to perform

0 1 2 3 4 5 6 7 8 9 10

Have you been treated for this pain recently? ▫ No. ▫ Yes

Does the pain keep you up at night? ▫ No. ▫ Yes

Social History:

Do you currently or have you ever smoked tobacco? ▫ Current ▫ Past (how many years? ___) ▫ Never

Roughly, how often do you consume alcohol? ▫ Never ▫ Monthly or less ▫ 2-4 times a month ▫ 2-3 times a week ▫ 4 or more times a week

Do you use recreational drugs? _____

Are you currently involved in substance abuse? ▫ Yes- current ▫ No, but in the past ▫ No- never

What activities/exercise do you perform and roughly how often?

_____

What position do you sleep in? ▫ Back ▫ Side ▫ Stomach

Do you use a pillow between your legs? ▫ No. ▫ Yes Do you hug a pillow? ▫ No. ▫ Yes

How do you manage stress? (therapy, have support, journal, meditate, medication, etc)

_____

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HEAD/FACE:
Headache/Migraine: ▫ Current ▫Past
Dizziness: ▫ Current ▫ Past
Memory Loss: ▫ Current ▫ Past
Seizure/Convulsion/Epilepsy: ▫ Current ▫ Past

EYES:
Blurred Vision: ▫ Current ▫ Past
Eyelid Twitching: ▫ Current ▫ Past
Floaters: ▫ Current ▫ Past
Eye Strain/Pain: ▫ Current ▫ Past
Recent Sudden Change in Vision: ▫ Current ▫ Past

NOSE:
Sinus Trouble: ▫ Current ▫ Past
Sinus Infection: ▫ Current ▫ Past
Nose Bleeds: ▫ Current ▫ Past
Deviated Septum: ▫ Current ▫ Past
Loss of Smell: ▫ Current ▫ Past

MOUTH:
Dental Problems: ▫ Current ▫ Past
Gum Problems: ▫ Current ▫ Past
Teeth Grinding: ▫ Current ▫ Past
Jaw Clenching/ TMJD: ▫ Current ▫ Past
Ulcers: ▫ Current ▫ Past
Unusual Taste: ▫ Current ▫ Past

THROAT:
Sore throat: ▫ Current ▫ Past
Hoarseness: ▫ Current ▫ Past
Difficulty swallowing: ▫ Current ▫ Past
Dryness: ▫ Current ▫ Past
Thyroid disorder: ▫ Current ▫ Past

RESPIRATORY:
Difficulty inhaling: ▫ Current ▫ Past
Difficulty exhaling: ▫ Current ▫ Past
Bronchitis: ▫ Current ▫ Past
Congestion: ▫ Current ▫ Past
Shortness of breath: ▫ Current ▫ Past
Fatigue: ▫ Current ▫ Past
Pain with breath: ▫ Current ▫ Past
Excessive coughing: ▫ Current ▫ Past
Asthma: ▫ Current ▫ Past

CHEST/HEART:
High BP: ▫ Current ▫ Past
Low BP: ▫ Current ▫ Past
Chest pain/tightness: ▫ Current ▫ Past
High Cholesterol: ▫ Current ▫ Past
Pacemaker: ▫ Current ▫ Past
Heart Dz: ▫ Current ▫ Past

CIRCULATION:
Anemia: ▫ Current ▫ Past
Clotting disorder: ▫ Current ▫ Past
Easy bruising: ▫ Current ▫ Past
Easy bleeding: ▫ Current ▫ Past
Cold limbs (hands/feet): ▫ Current ▫ Past
Arteriosclerosis: ▫ Current ▫ Past
Ankle swelling: ▫ Current ▫ Past
Raynaud's syndrome: ▫ Current ▫ Past
Varicose Veins: ▫ Current ▫ Past

GI SYSTEM:
Diabetes: ▫ Current Past
Always thirsty: ▫ Current ▫ Past
Never thirsty: ▫ Current ▫ Past
Excessive appetite: ▫ Current ▫ Past
Lack of appetite: ▫ Current ▫ Past
Gas/bloating: ▫ Current ▫ Past
Unexpected weight loss: ▫ Current ▫ Past
Stomach/abdominal pain: ▫ Current ▫ Past
Heartburn: ▫ Current ▫ Past
Nausea: ▫ Current ▫ Past
Liver Disease/hepatitis: ▫ Current ▫ Past
Diarrhea/loose stool: ▫ Current ▫ Past
Constipation: ▫ Current ▫ Past
Rectal bleeding: ▫ Current ▫ Past
Hemorrhoids: ▫ Current ▫ Past

URINATION:
Frequent: ▫ Current ▫ Past
Difficult/Painful: ▫ Current ▫ Past
Bleeding: ▫ Current ▫ Past
Nocturnal (night): ▫ Current ▫ Past
Kidney disease: ▫ Current ▫ Past
Kidney Stones: ▫ Current ▫ Past

SKIN:
Acne: ▫ Current ▫ Past
Dryness: ▫ Current ▫ Past
Moles: ▫ Current ▫ Past
Lumps: ▫ Current ▫ Past
Excessive sweating: ▫ Current ▫ Past
Night sweating: ▫ Current ▫ Past
Rarely sweat: ▫ Current ▫ Past

NEUROLOGICAL:
Tremors: ▫ Current ▫ Past
Numbness/Tingling: ▫ Current ▫ Past
Weakness: ▫ Current ▫ Past
Lack of Coordination (frequent falls, imbalance): ▫ Current ▫ Past
Nerve Pain (electrical/sharp): ▫ Current ▫ Past

SLEEP:
Insomnia/ trouble going to sleep/staying asleep: ▫ Current ▫ Past
Drowsiness-/ unrested sleep: ▫ Current ▫ Past
Excessive dreaming: ▫ Current ▫ Past
Waking easily: ▫ Current ▫ Past

JOINTS/BONES:
Arthritis: ▫ Current ▫ Past
Joint stiffness: ▫ Current ▫ Past
Joint swelling: ▫ Current ▫ Past
Scoliosis/ Spinal curvature: ▫ Current ▫ Past
Osteoporosis/penia: ▫ Current ▫ Past
Joint pain with weather: ▫ Current ▫ Past

REPRODUCTIVE:
Cramps: ▫ Current ▫ Past
Heavy Cycle: ▫ Current ▫ Past
Irregular cycle: ▫ Current ▫ Past
Hot Flashes: ▫ Current ▫ Past
Prostate issues: ▫ Current ▫ Past

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Review of symptoms: Mark all that apply **Others not listed:**

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