

Patient Information

Judith Boothby MS DC PC
1620 SE Ankeny St. Portland, Oregon 97214
(503) 233-0943 – phone & fax

Thank you for choosing Dr. Judith Boothby's office. In order to keep complete records please assist us by providing the following information.

Who referred you? _____

Today's Date ____/____/____

Patient Name: _____

Address: _____ City: _____

State: ____ Zip: _____ Home Phone: _____

Birthday: ____/____/____ Cell Phone: _____

Gender (circle): M F O Marital Status (circle): S M D W Partnered

Work Status (circle): Full Part Unemployed Retired Student

Employer _____ Work Phone: _____

Add e-mail to receive our newsletter: _____

Person Responsible for Payment when other than patient:

Name: _____

Address: _____ City: _____ State: _____

ZIP _____ Phone _____ Birthday ____/____/____

Employer: _____ Work Phone: _____

Emergency Contact: Name _____

Phone: _____

PERSONAL HEALTH HISTORY

Patient Name:

DOB:

Date:

Please check box if you ever had any of the following:

<input type="checkbox"/> Addictions: alcohol, food, drugs	<input type="checkbox"/> Cramps	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Lyme Disease
<input type="checkbox"/> AIDS	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Rashes, ever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia/Tiredness	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Irritability	<input type="checkbox"/> Rubella (German Measles)
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Disabilities	<input type="checkbox"/> Joint Instability	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Sexually Transmitted Diseases
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Sexual &/or Physical Abuse
<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Loss of Potency	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Gynecological Issues	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast Tenderness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Mental Health Disorders	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Burning, Tingling, Shooting Pain	<input type="checkbox"/> Heart Murmur/Disorder	<input type="checkbox"/> Menstrual Disorders	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tumor, Growth, Cyst
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Other:
<input type="checkbox"/> Children # _____	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pelvic Instability	
<input type="checkbox"/> Colds (frequent)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Polio	

List marked reactions to med /foods/etc:

Do You have a yearly pap smear? yes no

Do you conduct regular self-breast exams? yes no

Do you have a yearly prostate exam? yes no

What do you do for exercise?

Do you smoke? yes no

What is your cholesterol level? Test date:

HOSPITALIZATIONS / SURGERIES

DATES

ACCIDENTS / ILLNESSES (auto, sports, falls, etc.)

DATES

TESTS OR X-RAYS

DATES

FAMILY HEALTH HISTORY

<input type="checkbox"/> Addictions	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Heart Disease / Stroke	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> AIDS	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other major medical disorders Please list:
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Anemia / Tiredness	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental Health Disorders	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gall Bladder Disease	<input type="checkbox"/> Thyroid Problems	

CONFIDENTIAL CASE HISTORY

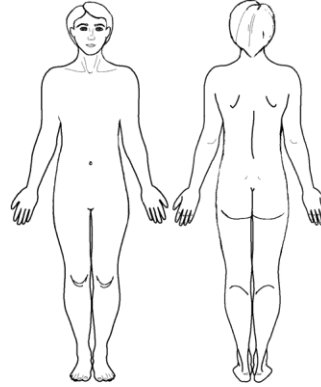
Please fill this out as completely as possible. This is confidential and will only be shared with your written permission.

Patient Name:	DOB:	Date:
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CURRENT HEALTH

Reason for visit:
When did this problem start? Be specific.
What makes you feel better?
What makes you feel worse?
With what activities does your pain interfere? (work, sleep, sex, daily routine)
Does the pain radiate? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to where:
Does <input type="checkbox"/> coughing, <input type="checkbox"/> sneezing, <input type="checkbox"/> forceful bowel movement aggravate your condition?
Are you having any problems with urination or bowel movements? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain
Is there a daily pattern to your pain? No pain ----- Pain as bad as it can be
What other issues regarding your health concern you?
Are you currently receiving medical care: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list providers and type of care below:
List medication & dosage, taken within the last two months including vitamins, over-the-counter drugs, herbs, etc.

Please indicate areas of pain, concern or discomfort on the model below.



Rate your ability to perform daily tasks.

← Optimal Unable →

|-----|

Rate your severity of pain in the past week.

← No Pain Pain as bad as it could be →

|-----|

Pain Quality

A-Ache

S-Sharp

B-Burning

N-Numbness

P-Pins & Needles

O-Other

Frequency Of Pain

___ Daily

___ Hourly

___ Other

ARE YOU NOW HAVING PROBLEMS WITH: Explain briefly

<input type="checkbox"/> Allergies	<input type="checkbox"/> Genitals	<input type="checkbox"/> Nose
<input type="checkbox"/> Arms	<input type="checkbox"/> Hands	<input type="checkbox"/> Reproductive Organs
<input type="checkbox"/> Back	<input type="checkbox"/> Headache	<input type="checkbox"/> Sexual Energy
<input type="checkbox"/> Bladder	<input type="checkbox"/> Heart	<input type="checkbox"/> Sleep
<input type="checkbox"/> Bowels	<input type="checkbox"/> Kidneys	<input type="checkbox"/> Stomach
<input type="checkbox"/> Ears	<input type="checkbox"/> Legs	<input type="checkbox"/> Teeth
<input type="checkbox"/> Eyes	<input type="checkbox"/> Lungs	<input type="checkbox"/> Throat
<input type="checkbox"/> Eating	<input type="checkbox"/> Moods	<input type="checkbox"/> Weight
<input type="checkbox"/> Energy	<input type="checkbox"/> Neck	<input type="checkbox"/> Urination
<input type="checkbox"/> Feet	<input type="checkbox"/> Nerve Pain	<input type="checkbox"/> Other

Informed Consent for Chiropractic Treatment

To the patient: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential benefits and risks involved with the recommended treatment. The following information will assist your decision-making.

The plan of this chiropractic therapy is to help your nervous system and myofascial system convert from scar tissue and holding patterns to a system that balances and self regulates. This treatment, in combination with therapeutic exercise, will correct muscular skeletal alignment, relieve stress from the nervous system and organs, and restore balance. As the status quo of your body changes, you may experience emotional and physical feelings, including a sense of confusion. These sensations mark important healing progress and need to be experienced. Stopping treatment at this point creates a risk of decreased stability.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by Judith Boothby, DC, and or other licensed Doctors of Chiropractic working at the clinic, office or other locations.

I have had the opportunity to discuss my condition with Dr Boothby, including the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that the risks to chiropractic treatment include, but are not limited to: broken bones, dislocations, sprains and strains, worsening and aggravation of spinal conditions, decreased stability, increased symptoms and pain, no improvement of symptoms or pain.

In rare cases, there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I am aware that alternative courses of treatment include allopathic medical care, painkillers, acupuncture, naturopathic, physical therapy and massage. I will ask if I have questions about any other treatments.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment:

I have read, or have had the above consent read to me. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover any course of treatment with Dr. Boothby.

Patient:

Print name

DOB: _____

Signature of patient

Date signed

Witness to patient's signature

Date signed

Patient's representative:

Print name of patient's representative

Signature of patient's representative

Relationship/authority of representative

Date signed

Dr. Judith Boothby's Office Policies & Fees

Judith Boothby MS DC PC
1620 SE Ankeny
Portland, Oregon 97214
(503) 233-0943 – phone & fax

HIPAA:

We are a required by law to maintain the privacy of protected health information, and also to provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. Your signature below is an acknowledgement that you have received a Notice of Privacy Practices Summary.

IDENTITY THEFT:

At your first appointment, we will ask to see your government issued picture ID. This task is because of FTC Identity Theft regulations.

PAYMENT POLICY:

Payment is due when services are rendered (except MVA claims). Payment can be made with cash, check or credit/debit. Make checks payable to: **Judith Boothby MS DC PC**

You are responsible for billing your medical insurance company. It is your responsibility to check with your insurance company to determine chiropractic coverage. After paying Dr. Boothby for her services, you can submit a copy of her insurance receipt (SuperBill) to your individual insurance provider. The receipt contains the necessary diagnostic and treatment codes required by the insurance company to process the claim.

*****If you need a receipt please ask for one at check-out*****

CANCELLATIONS:

***** 24 hour notice or \$50.00 No Show Fee *****

You are required to provide us with 24-hour notice of cancellation. If you do not cancel with at least 24- hour notice or just do not show up you will be charged a “no show fee.” The fees are **\$50.00** for Dr’s appointments and **\$20.00** for exercise appointments. If you consistently do not show up for appointments, Dr. Boothby will terminate treatment.

FEES:

Initial Office Visit: \$150 (Adults, approximately ¾ hour)
\$95 - \$130 (Children approximately ½ hour)

Return Office Visit: \$95 - \$130 (Adults – approximately ½ hour)
\$65 (Adults – approximately ¼ hour)
\$65 (Children, Seniors)

ACKNOWLEDGEMENT:

Patient Name _____ DOB _____

Date _____

Signature of Patient or Legal Representative

Relationship _____

Printed Name of Representative

Picture ID examined

HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, or health care operations and for other purposes that are permitted or required by law.

1. Uses and Disclosures of Protected Health Information

Treatment Payment Health Care Operations

2. Permitted and Required Uses and Disclosures That May Be Made With Your Authorization and Opportunity to Object

We may use and disclose your protected health information in the following instances:

Facility Directories Psychotherapy notes (for TPO)
Others involved in Your Health Care Marketing
Emergencies

3. Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent:

Required by Law	Public Health
Communicable Diseases	Health Oversight
Legal Proceedings	Abuse or Neglect
Law Enforcement	Criminal Activity
Research	Inmates
Workers' Compensation	Food and Drug Administration
Military Activity and National Security	Required Uses and Disclosures
Coroners, Funeral Directors, and Organ Donation	

4. Your Rights

Following is a statement of your rights with respect to your protected health information and how you may exercise these rights. You have the right to:

Inspect and copy your protected health information
Request a restriction of your protected health information
Request to receive confidential communications from us by alternative means or at an alternative location
Have your physician amend your protected health information
Receive an accounting of certain disclosures we have made, if any, of your protected health information
Obtain a paper copy of this notice from us

5. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.