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:

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

[ ] Addictions	[ ] Back Problems	[ ] Heart Disease / Stroke	[ ] Tuberculosis
[ ] AIDS	[ ] Breast Cancer	[ ] High Blood Pressure	[ ] Other major medical disorders Please list:
[ ] Allergies	[ ] Cancer	[ ] Kidney Disease	
[ ] Anemia / Tiredness	[ ] Diabetes	[ ] Liver Disease	
[ ] Appendicitis	[ ] Epilepsy	[ ] Mental Health Disorders	
[ ] Arthritis	[ ] Gall Bladder Disease	[ ] 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:

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? [ ] Yes [ ] No If yes, to where:

Does [ ] coughing, [ ] sneezing, [ ] forceful bowel movement aggravate your condition?

Are you having any problems with urination or bowel movements? [ ] Yes [ ] No If yes, please explain

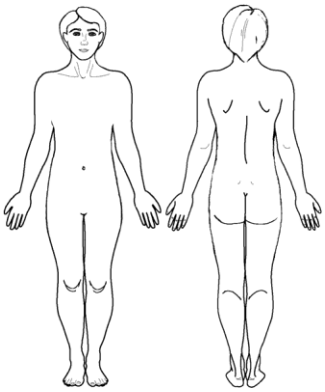
Is there a daily pattern to your pain?
No pain |----------| Pain as bad as it can be

What other issues regarding your health concern you?

Are you currently receiving medical care: [ ] Yes [ ] 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

[ ] Allergies	[ ] Genitals	[ ] Nose
[ ] Arms	[ ] Hands	[ ] Reproductive Organs
[ ] Back	[ ] Headache	[ ] Sexual Energy
[ ] Bladder	[ ] Heart	[ ] Sleep
[ ] Bowels	[ ] Kidneys	[ ] Stomach
[ ] Ears	[ ] Legs	[ ] Teeth
[ ] Eyes	[ ] Lungs	[ ] Throat
[ ] Eating	[ ] Moods	[ ] Weight
[ ] Energy	[ ] Neck	[ ] Urination
[ ] Feet	[ ] Nerve Pain	[ ] 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, mind-body neurological exercises 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 of chiropractic treatment include, but are not limited to: broken bones, dislocations, nerve damage, 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, massage or refusing care. I will ask if I have questions about any other treatments. I understand that there is a risk associated with refusing care.

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:	***Patient's representative:***
_____DOB:_____	_____
Print name	Print name of patient's representative
_____	_____
Signature of patient Date signed	Signature of patient's representative Date signed
_____	_____
Witness to patient's signature Date signed	Relationship/ authority of representative

Dr. Judith Boothby's Office Policies & Fees

Judith Boothby MS DC PC
1620 SE Ankeny
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(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). Payments can be made by cash, check or credit/debit card.

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 **$25.00** for exercise appointments. If you consistently do not show up for appointments, Dr. Boothby will terminate treatment.

FEES:

Initial Office Visit:	$155 (Adults, approximately ¾ hour)
	$100 - $135 (Children approximately ½ hour)
Return Office Visit:	$100 - $130 (Adults – approximately ½ hour)
	$70 (Adults – approximately ¼ hour)
	$70 (Children, Seniors)
	$60 (Exercise Class)

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.