Patient Information

Name: ______________________ DOB: ___ / ___ / ___

Address: ______________________ Email: ____________ @ ____________ .com

City: ______________________ Primary Phone: ( ) -

State: ____________ Zip Code: ____________ Scondary Phone: ( ) -

Employer: ______________________ Emergency Contact Name: ______________________

Occupation: ______________________ Emergency Contact Phone: ( ) -

☐ Male ☐ Female Height: ___ ' ___ " Weight: ______ lbs. Primary Care Physician: ______________________

☐ Single ☐ Married Any previous chiropractic care? ☐ No ☐ Yes Primary Care Facility: ______________________

Good experience? Please tell us. ______________________ Primary Care Phone: ( ) -

Date Last Examined: ___ / ___ / ___

Insurance Information

Please provide all information relevant to your own insurance / medical coverage if you are the responsible party.

Insurance Company: ______________________

Type of Insurance: medical / car accident coverage

Subscriber's Name: ______________________

Relationship to Subscriber: self / spouse / parent / other ______

Insured Subscriber's DOB: ___ / ___ / ___

Medical Insurance Policy # ______________________

Car Accident Claim # ______________________

Please provide all information relevant to insurance / medical coverage for responsible party, if it is someone other than yourself.

Insurance Company: ______________________

Type of Insurance: medical / car accident coverage

Subscriber's Name: ______________________

Relationship to Subscriber: self / spouse / parent / other ______

Insured Subscriber's DOB: ___ / ___ / ___

Medical Insurance Policy # ______________________

Car Accident Claim # ______________________

Accident Information

Date of Car Accident: ___ / ___ / ___ Cross streets of accident: ______________________

Your car model: ____________ Speed: ____ mph Other car: ____________ Speed: ____ mph Police on scene? ☐ No ☐ Yes

What part of the other vehicle was impacted? ______________________

What part of your vehicle was impacted? Describe damage. ______________________

How did you leave? Any other details you would like to share? ______________________

Health History

Name: ______________________ DOB: __________

What are the reasons your seeking treatment today? ______________________

Have you attempted any other forms of treatment for the above? If so, please describe, and rate their success. ______________________

Please list any allergies (seasonal, foods, pharmaceutical), food sensitivites or food cravings that you have. ______________________

Please list any current medications, OTCs and / or supplements with dosages if possible: ______________________

Please check if you partake in any of the following and provide details on frequency / amount:

- ☐ Coffee / Black Tea (caffeine) ______________
- ☐ Water ______________
- ☐ Tobacco ______________
- ☐ Soda Pop ______________
- ☐ Alcohol ______________
- ☐ Exercise ______________

Please list any imaging, illnesses, surgeries, or major hospitalizations you have or had.

Image	Approximate Date	Description
CT/MRI/X-ray/Surgery/Hospital/Illness		
CT/MRI/X-ray/Surgery/Hospital/Illness		
CT/MRI/X-ray/Surgery/Hospital/Illness		
CT/MRI/X-ray/Surgery/Hospital/Illness		
CT/MRI/X-ray/Surgery/Hospital/Illness		

Please provide information on any ***prior*** motor vehicle accident descriptions, speeds, other car models, your car model, seat-belt used, position of head and torso at impact, arm position and any other information to accurately describe the incident.

____

Family History

Please provide information on any serious illness or disorder that may run in your family (i.e., hypertension/HBP, lung disease, cancer, diabetes, heart disease, thyroid, breast, prostate, etc.) and include the family member's relationship.

____

Skyline Chiropractic LLC
1750 SW Skyline Boulevard Suite 223 Portland, OR 97221
Wesley Wallis, DC
971 • 226 • 7025

AUTHORIZATION TO RELEASE INFORMATION

By completing and signing this form, you are authorizing Wesley Wallis D.C. and / or Skyline Chiropractic LLC to release your health information to your insurance company for benefits verification and billing purposes or to release records to another provider or facility. This form may also be used to obtain records from another provider or facility on your behalf and determine your best course of care.

To Be Read and Signed by Patient

I understand the following:

I may revoke this authorization at any time by providing written notice to the practice. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage. The practice will not condition treatment or payment based on my signing this authorization. I acknowledge that I have had an opportunity to read and review this authorization and understand its purpose. I may request a copy of this authorization at any time.

"I hereby authorize Skyline Chiropractic LLC and Dr. Wallis D.C. to make use and disclosure of my protected health information (information in my medical and / or financial records) as indicated below."

Patient's Name {Please Print} | Date of Birth

Signature of Patient {or Guardian, if Patient is a Minor} | Date of Signature

Records Release

I, the patient, ____________________________________ hereby give consent to ________________________________ to access my information concerning my selected records. By selecting none of each below, I give Skyline Chiropractic LLC and Dr. Wallis D.C. permission for all uses.

☐ Financial / Insurance ☐ Schedule ☐ Medical ☐ Other (specifiy) ________________________________

Signature of Patient {or Guardian, if Patient is a Minor} | Date of Signature

CONSENT FOR EXAMINATION AND TREATMENT

I understand that Skyline Chiropractic LLC and Dr. Wesley Wallis D.C. is a professional providing a healthcare service. I acknowledge that during the course of my care, I (or the person named below, for whom I am legally responsible) may receive chiropractic adjustments through human to human contact. Treatment may include other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays (if needed), Graston / IASTM (aka instrument assisted soft tissue manipulation), therapeutic massage and physical therapy.

To Be Read and Signed by Patient

I understand the following:

There are some risks inherent to treatment. If I receive chiropractic, the most common risks are temporary aggravation of my condition, inflammation, and soreness. Risks that are more rare include (but are not limited to); fractures, stroke, dislocations, sprains, burns, and aggravation of disc injury.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on his judgment to exercise the avoidance if possible of these risks during the course of the procedure(s) which he feels at the time, based on the facts then known, is in my best interests and health.

"I hereby agree to the above-mentioned procedure(s). I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment."

Patient's Name {Please Print} ______________________ Date of Birth ___ . ___ . ___

Signature of Patient {or Guardian, if Patient is a Minor} ______________________ Date of Signature ___ . ___ . ___

FINANCIAL POLICY

Skyline Chiropractic LLC and Dr. Wesley Wallis D.C. are committed to providing you with the best possible care. We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. Your insurance coverage is a contract between you, possibly your employer, and the insurance company. We are not a party to the contract. Costs for all services rendered to you are your financial responsibility. However, we realize that insurance companies need processing time and total amounts due by patient responsibilty/co-pay or percentages will be given time to process as well as be paid to Dr. Wallis. All charges will become due and payable if the insurance company does not reimburse Wesley Wallis or Skyline Chiropractic LLC within 45 days of services rendered. If fees or services are not paid it is at the provider's discretion to send them to collections.

Please familiarize yourself with your insurance policy and its requirements. We can help you but we do not know details of your

As a courtesy, we will bill your insurance company, but all co-pays and uncovered services are due at the time of delivery of statements and as stated, given 45 days to reimburse Skyline Chiropractic LLC and Dr. Wesley Wallis D.C..

To Be Read and Signed by Patient

I understand the following:

I, the patient, ____ am responsible for all charges incurred, regardless of insurance coverage. In the event my account is not payable in full to Skyline Chiropractic LLC, I will contact them for a payment plan prior to 45 days of date of statement. In the event my account is referred to a collection agency due to lack of payment on my part, I agree to pay 100% of all collection / legal fees Skyline Chiropractic LLC incurs which will be added to my account. Payment plans are all set to the discretion of the provider and may have different lengths and payment amounts.

Returned Checks: A $35 insufficient fund fee will be charged to your account for each returned check.

Missed Appointment: In an effort to ensure all our patients have the opportunity to be seen when needed, a $35 fee will be applied directly to you (not the insurance) for missed or rescheduled appointments without 24 hour prior notice. Thank you for your understanding and consideration of others.

______________________________   ______ . ______ . ______

Patient's Name {Please Print}   Date of Birth

______________________________   ______ . ______ . ______

Signature of Patient {or Guardian, if Patient is a Minor}   Date of Signature