

Sunnyside Health Center & Chiropractic Clinic, PC

PATIENT INTAKE FORM

Please fill out this form completely

Name: _____ Todays Date _____

Home Phone: _____ SS #: _____ Date of Birth: _____

Address: _____

City: _____ State/Prov: _____ Postal code: _____

Occupation: _____ Work phone: _____

Best time to reach you: _____ May we call you at work? Yes No

Single Married ζ Spouse's name: _____ I use Shaklee products

Health Concerns: _____

Where may we reach you during your stay in Portland? _____

Referred by: _____ Uses Shaklee products

Their phone # so that we may thank them: _____

Previous Treatment

Physician: _____ (Select one) DC ND DO M.D. Other _____

Address: _____ Phone: _____

Diagnosis: _____ Treatment: _____

Results: _____

Physician: _____ (Select one) DC ND DO M.D. Other _____

Address: _____ Phone: _____

Diagnosis: _____ Treatment: _____

Results: _____

Informed Consent

While the therapies at Sunnyside Health Center may benefit health, I understand that no promise of cure is made. I understand that the procedure known as metabolic evaluation is not a chiropractic or medically recognized technique of diagnosis or treatment of any disease or condition. I understand that the procedure is experimental and is for the purpose of gathering data to compare with orthodox procedures. I accept responsibility for my health. Sunnyside Health Center does not guarantee any particular benefit beyond that of improved nutritional awareness.

Patient's Signature: _____ Date: _____

Financial Information

Payment, in full, is due at the time services are rendered.¹ Sunnyside Health Center accepts Visa, MasterCard, cash and checks. When you settle your account, at the end of your visit, you will receive a Diagnosis & Procedures Form that lists the services rendered and the diagnosis that the doctor made. You may send the Diagnosis & Procedures Form to your insurance provider and they will reimburse you in accordance with your insurance policy. Because policies vary, you should learn your insurance company's coverage policies and submission requirements prior to receiving services at this clinic. A list of Sunnyside's procedures with customary charges and CPT codes (insurance billing codes) is available upon request.

We do not bill insurance. Although we attempt to keep our diagnostic and procedure codes up to date, we cannot guarantee the accuracy of the codes we provide. If you are having difficulty receiving reimbursement, contact your insurance agent, or a third party collection service for assistance. The health care providers at Sunnyside Health Center devote their energies to meeting their patients needs in the most effective way possible and, therefore, are not enrolled in any insurance programs.

I understand that I am personally responsible for all charges incurred at Sunnyside Health Center. Should collection processes become necessary, I will assume responsibility for any and all collection fees, interest accrued¹, court costs, and attorney's fees involved. I hereby authorize Sunnyside Health Center to furnish information concerning my illness or injury to my insurance company or attorney.

I have read, and I accept, the financial arrangements listed above.

Patient's Signature: _____ Date: _____

- This patient is a minor. I hereby give permission to the doctors of this office and whomever they designate to attend the patient. I am the patient's legal guardian. I accept financial responsibility for this patient.

Guardian's Signature: _____ Date: _____

Do you plan to make an insurance claim for care received at this clinic? No Yes

If "Yes" list Insurance company name : _____

Medical Assistance Participants

If you are a medical assistance program participant (Medicare, Medicaid, Oregon Health Plan, Care Oregon, etc.) please complete the rest of this form.

In addition to the provisions agreed to in the rest of this form, I understand that the services performed at Sunnyside Health Center are not generally covered for payment by medical assistance programs. If I choose to obtain services at Sunnyside Health Center, I agree to be personally responsible for all aspects of my account including paying the financial charges for any and all services rendered. All services rendered will be charged at the customary rate.

Patient's Signature: _____ Date: _____

¹ Outstanding balances will be charged a 2% **monthly** interest rate (24% APR). Checks that can not be cashed (due to stop payment, Non-Sufficient Funds, etc.) will be charged a fee up to \$25 per check.