CompleteCare Health Centers

Name _____ Date _____

Please check all that apply. Do you have any of the following? (Avg. time to complete: 30 seconds)

☐ yes ☐ no Diabetes

Would you like to get rid of your diabetes? ☐ yes ☐ no

☐ yes ☐ no Sleep Apnea and/or CPAP machine

Would you like to get rid of your Sleep Apnea? ☐ yes ☐ no

☐ yes ☐ no Fibromyalgia

Would you like to get rid of your Fibromyalgia? ☐ yes ☐ no

☐ yes ☐ no I.B.S. (Or other digestive issues, GERD, constipation, etc)

Would you like to get rid of your IBS? ☐ yes ☐ no

☐ yes ☐ no Neuropathy (or Peripheral Neuropathy)

Would you like to get rid of your Neuropathy? ☐ yes ☐ no

☐ yes ☐ no High Blood Pressure

Would you like to get rid of your High Blood Pressure? ☐ yes ☐ no

☐ yes ☐ no Overweight

Would you like to be your ideal weight? ☐ yes ☐ no

☐ yes ☐ no Arthritis

Would you like to get rid of your Arthritis? ☐ yes ☐ no

☐ yes ☐ no Pain- either neck, back and/or headaches

Would you like to get rid of your pain? ☐ yes ☐ no

☐ yes ☐ no Thyroid issues (hypo/hyperthyroidism or Hashimoto's)

Would you like to get rid of your pain? ☐ yes ☐ no

☐ yes ☐ no Other Concerns:_____

Would you like to get rid of this concern? ☐ yes ☐ no

Would you like information on the items you marked "yes" on above? ☐ yes ☐ no

Would you like a consultation on how to get rid of the item(s) you checked yes so you can reduce or eliminate the need for drugs/surgery? ☐ yes ☐ no

Phone Number: _____

Email (please print clearly)_____

Staff use only:	Initials
Clarified request with patient:	_____
Emailed/delivered requested information:	_____
Scheduled (yes/no)	_____
Patient Case Type	_____

CompleteCare Health Centers

MEDICAL HISTORY

Patient Name: _____ **DOB**_____ **Date:** _____

Phone #:_____**May we leave confidential voicemails at this number? Y / N** **Sex:** ☐ **Male** ☐ **Female**

How did you hear about us?_____ **Current Job/Occupation:**_____

Reason for today's visit:_____ **Emergency Contact:**_____ **Phone:**_____

Marital Status:_____ **Have you ever received medical treatment under a different last name? Y / N If yes, list name:** _____

PAST MEDICAL HISTORY: Have you had any of the following conditions?

❑ Diabetes	❑ Tuberculosis	❑ Brain or Nerve Disease	❑ Arthritis
❑ Thyroid Disorder	❑ Blood Clots or Phlebitis	❑ Liver Disease /Hepatitis	❑ Ulcers
❑ High Blood Pressure	❑ Depression/Anxiety	❑ Heart Disease/Problems	❑ Migraine
❑ Cholesterol Problems	❑ Kidney Disease/Stones	❑ Sexually Transmitted Disease	❑ Seizures
❑ Lung Disease	❑ Abnormal Skin Test	❑ Acid Reflux or Hiatal Hernia	❑ Asthma
❑ Osteoporosis	❑ Environmental Allergies	❑ Cancer Type:_____	❑ Other:_____

LIST ALL CURRENT MEDICATIONS (Including non-prescription and vitamins)

Name	Dosage	Route	Frequency

LIST ALL MEDICATION ALLERGIES (Including reaction):_____

LIST ALL HOSPITALIZATIONS FOR MAJOR ILLNESSES OR SURGERIES:

Date	Operation/Hospitalization	Complications

Date	Severe Accidents and Injuries

FAMILY HISTORY:

	Age at death	Age if alive	General Health; Major health problems:
Mother			
Father			
Sibling			
Sibling			

FAMILY HISTORY OF ANY OF THE BELOW CONDITIONS: (Check any boxes that apply)

❑ Thyroid Disease	❑ Diabetes	❑ Osteoporosis	❑ Blood Clots	❑ Cancer	❑ Ulcers	
❑ High Blood Pressure	❑ Stroke	❑ Mental Illness	❑ Heart Attack	❑ TB	❑ Alcoholism	

SOCIAL HISTORY:

Alcohol use: **# of drinks per day:**_____ **What age did you start drinking?**_____ **Year Quit:** _____

Tobacco use: **Type:**_____ **# Per day:**_____ **What age did you start?**_____ **Year Quit :**_____

Coffee use: **# of drinks per day:**_____ **Energy Drink use:** **# of drinks per day:**_____ **History of Drug abuse: Yes / No**

Flu Vaccine Y N **Date:**_____

Tetanus Booster Y N **Date:**_____

Pneumonia Y N **Date:**_____

Hepatitis B Y N **Date:**_____

Date of last colonoscopy: _____

Typical breakfast:_____

Typical lunch:_____

Typical dinner:_____

Typical snacks: _____

How often do you exercise?_____

What is your workout?_____

CompleteCare Health Centers

Patient Name: _____

REVIEW OF SYMPTOMS: (Please check each item "yes" or "no" as they relate to your health)

CONSTITUTIONAL:	Yes	No
Weight Loss	❑	❑
Fatigue	❑	❑
Fever	❑	❑

EYES:		
Glasses/Contacts	❑	❑
Eye Pain	❑	❑
Double Vision	❑	❑
Cataracts	❑	❑

EAR, NOSE, THROAT:		
Difficulty hearing	❑	❑
Ringing in ears	❑	❑
Vertigo	❑	❑
Sinus trouble	❑	❑
Nasal stuffiness	❑	❑
Frequent sore throat	❑	❑

CARDIOVASCULAR:		
Murmur	❑	❑
Chest pain	❑	❑
Palpitations	❑	❑
Dizziness	❑	❑
Fainting spells	❑	❑
Shortness of breath	❑	❑
Difficulty lying flat	❑	❑
Swelling ankles	❑	❑

ENDOCRINE:		
Hair Loss	❑	❑
Heat/cold intolerance	❑	❑
PMS	❑	❑
Hot flashes	❑	❑
Decreased sex drive	❑	❑

RESPIRATORY:	Yes	No
Cough	❑	❑
Coughing blood	❑	❑
Wheezing	❑	❑
Chills	❑	❑

GASTROINTESTINAL		
Heartburn/Reflux	❑	❑
Nausea/Vomiting	❑	❑
Constipation	❑	❑
Change in BM's	❑	❑
Diarrhea	❑	❑
Jaundice	❑	❑
Abdominal Pain	❑	❑
Black or bloody BM	❑	❑

GENITOURINARY:		
Burning/frequency	❑	❑
Nighttime	❑	❑
Blood in urine	❑	❑
Erectile dysfunction	❑	❑
Abnormal discharge	❑	❑
Bladder leakage	❑	❑

PSYCHIATRIC:		
Anxiety/Depression	❑	❑
Mood Swings	❑	❑
Difficulty sleeping	❑	❑
Suicidal thoughts	❑	❑

HEMATOLOGY/LYMPH:	Yes	No
Bruise easily	❑	❑
Gums bleed easily	❑	❑
Enlarged glands	❑	❑

MUSCULOSKELETAL:		
Joint Pain/Swelling	❑	❑
Stiffness	❑	❑
Muscle Pain	❑	❑
Back Pain	❑	❑

SKIN:		
Acne	❑	❑
Rash/Sores	❑	❑
Lesions	❑	❑
Itching/Burning	❑	❑

NEUROLOGICAL:		
Loss of Strength	❑	❑
Numbness	❑	❑
Headaches	❑	❑
Tremors	❑	❑
Memory Loss	❑	❑

FEMALES ONLY:

Are you pregnant?	❑
Are you trying to become pregnant?	❑
Date of last period:	_____
Date of last pap:	_____
Last mammogram:	_____
Last DEXA scan:	_____
Age of onset periods:	_____
Periods Regular?	Yes / No
Are you on Replacement Hormones?	Yes / No

How often do you take antibiotics? _____ Less than once a year _____ 2-3 times per year _____ 4 times or more per year/Long course

_____ _____

Patient Signature **Date**

Please complete this page if you are receiving any of the following services:

Chiropractic, Physical Therapy, Massage Therapy, Exercise Therapy

Patient Name: _____ **DOB**_____ **Date:**_____

Have you had previous chiropractic care? Yes / No If Yes, when?: _____

Current Complaint: _____**How long have you had this condition?** _____

Is this condition due to: A work injury? Yes / No An auto accident? Yes / No Other Injury? Yes / No

How did this condition occur? _____

What aggravates this condition? _____**What helps your symptoms?** _____

Have you had similar conditions in the past? Yes / No Other Complaints: _____

Other physicians seen for this condition: _____

Any recent illnesses or infections? Yes / No If yes, please explain: _____

Have you been on antibiotics in the last two months? Yes / No Levaquin or Cipro? Yes / No

Any fractures in last 6 months? Yes / No Any joint replacements? Yes / No Any rib injuries? Yes / No

Have you had: any spinal surgeries? Yes / No If yes, please explain: _____

What are the physical demands of your job or hobbies?: _____

How many days per week do you exercise? _____ **What type of exercise?** _____

Sleep position (most common)? Side___ Back ___ Stomach ___ Recreational activities? _____

Are you currently pregnant? Yes / No Do you have breast implants? Yes / No Have you had a hysterectomy? Yes / No

Are you on replacement hormones? Yes / No

What aspect of your health are you most unhappy with? _____

QUADRUPLE VISUAL ANALOGUE SCALE

No pain 1 – What is your level of discomfort RIGHT NOW? Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

No pain 2 – What is your TYPICAL or AVERAGE level of discomfort? Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

No pain 3 – What is your level of discomfort AT ITS BEST (How close to "0" does your pain get)? Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

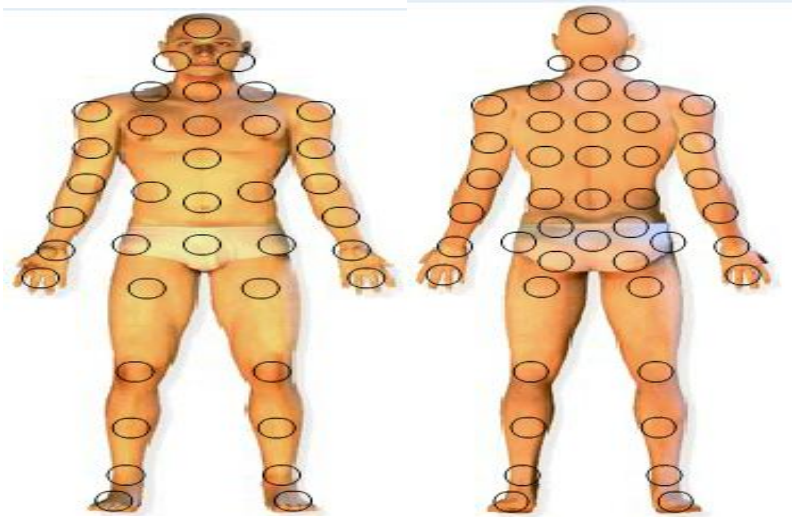
No pain 4 – What is your level of discomfort AT ITS WORST (How close to "10" does your pain get)? Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Never 5 – What percentage of the time are you in pain)? Constantly

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Please indicate the areas of your pain on the following figures:



Additional information you would like us to know:

_____

_____

_____

_____

PATIENT REGISTRATION

Patient Name: _____ Date of Birth: _____
Last First Middle
ADDRESS:_____
Street # or P.O. Box City State Zip
E-Mail ADDRESS: _____Social Security#: _____Marital Status: _____Sex: _____

Home Phone #: _____ Cell #:_____Work #: _____

Employer_____Occupation_____
HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME? Yes___No___ IF YES, UNDER WHAT NAME? _____
How did you hear about us?_____

GUARANTOR OR CUSTODIAL PARENT (RESPONSIBLE PARTY if different from patient)

Name: _____Date of Birth: _____Relationship to Patient:_____
Last First Middle
ADDRESS:_____
Street # or P.O. Box City State Zip
E-Mail ADDRESS: _____Social Security#: _____Marital Status: _____Sex: _____

Home Phone #: _____Cell #: _____Work #: _____

Employer_____Occupation_____

EMERGENCY CONTACT: SPOUSE, PARENT, RELATIVE, CLOSE FRIEND (circle one)

Name: _____ Relationship: _____Date of Birth: _____
Last First Middle
ADDRESS:_____
Street # or P.O. Box City State Zip
E-Mail ADDRESS: _____ Home Phone #: _____ Cell #: _____

INSURANCE INFORMATION: (Please check all that apply) (PLEASE PRESENT INSURANCE, MEDICARE OR OREGON HEALTH PLAN CARD TO RECEPTIONIST) I HAVE: Medicare_____ OHP_____ Health Insurance_____ No Insurance_____
MEDICARE: ID#_____PRIMARY CARE PROVIDER_____
OREGEON HEALTH PLAN Yes___ No___
PRIMARY HEALTH INSURANCE:_____Policy#_____Group#_____
INSURED NAME_____DOB_____SEX_____RELATIONSHIP TO PATIENT_____
EMPLOYER_____EMPLOYER ADDRESS_____
SECONDARY HEALTH INSURANCE: :_____Policy#_____Group#_____
INSURED NAME_____DOB_____SEX_____RELATIONSHIP TO PATIENT_____
EMPLOYER_____EMPLOYER ADDRESS_____
I am receiving medical treatment as a result of an accident Yes___ No___ **(If yes please complete accident report form)**
Motor Vehicle Accident_____ Work Related Accident_____ Other Accident_____
Consent for medical treatment: _____**Date:** _____

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to Complete Care for any services rendered. I understand I am financially responsible for all charges whether or not they are covered by insurance. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

****YOUR EMAIL ADDRESS MAY BE USED FOR ELECTRONIC NEWSLETTERS FOR COMPLETE CARE AND DR THAD GALA, DC****

Signature_____Date_____
Authorized Signature

CompleteCare Health Centers

FINANCIAL POLICY

Please review and initial each policy listed below.

_____ **Private Pay Primary Care (Self Pay):** I understand that if I do not have health insurance, $125.00 minimum is due at the time of service.

_____ **Policy Benefits/Non-Covered Charges:** I understand that it is my responsibility to know my insurance policy coverage and benefits and will notify Complete Care of any insurance changes in a timely manner. (Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. Services rendered may be considered non-covered by insurance and/or may be subject to deductible in addition to a copay.) I understand that I have the right to refuse any service before they are rendered if I think that are non-covered services or not payable by my insurance.

_____**Out-of-Network Insurance Plans:** I understand that full payment is required if I choose to be seen using an out-of-network insurance plan.

_____**In-Network Insurance Plans:** I understand that I must provide a copy of my current insurance card in order to file an insurance claim. If I do not have my insurance card, self-payment guidelines will apply and $125 minimum will be collected at the time of service for my primary care visit. I authorize the release of my medical information necessary to process an insurance claim on my behalf. I understand and agree to this financial policy. I request that my medical insurance carrier make any payments to Complete Care for services rendered to me.

_____**Copayments:** I understand that all copays are due at the time of my appointment and before I see the provider.

_____**Account Balances:** I understand that if I have a balance on my account I will receive a monthly statement until the account is paid in full. Bills are due and payable upon receipt of this monthly statement. Complete Care will bill my insurance for me if I provide the appropriate billing information. My insurance will make payment directly to Complete Care and I will be responsible for any deductible, co-payments, patient balances or co-insurances.

_____**Managed Care (Medicaid):** I understand that my insurance coverage is based on funding levels. There are some diagnoses that are considered non-covered and my insurance will not pay for any additional visits for this condition. (We have a payment plan for any patients who would like to schedule follow-up and/or elected procedure for any non-covered conditions. If you are interested in this option please let the provider know and the process will be started. In addition, some of the medications recommended today for treatment may not be covered and can be quite expensive. We will not submit any prior authorizations for these medications.)

_____**Medicare Patients:** Complete Care is a participating provider with Medicare. Medicare will pay 80% of what they allow, minus your annual deductible. If this has not been met, you will be responsible for the deductible and the 20% of allowable charges. Also, by signing this agreement, you authorize any holder of medical or other information regarding the patient names above to release such information to the Social Security Administration effective from this date.

_____**Ancillary Services:** I understand that it is my responsibility to know from whom my insurance company requires me to obtain any labs, x-rays, or any other ancillary services. Please let your providers medical staff know so that they may schedule these services accordingly. If your provider orders any tests not processed here at Complete Care they will be sent to an outside reference laboratory. If you have labs processed at more than one facility, you could receive a statement from both Complete Care and the outside laboratory with any out-of-pocket expense as well as two EOB's (explanation of benefits) from your insurance company. Sarah Roberson, FNP is the Clinical Consultant for Complete Care, laboratory and her name will be noted on the EOB as referenced above. It is often necessary to send some laboratory specimens and pathology to outside laboratories. If you have questions regarding charges from one of these services, you will need to contact the outside entity directly.

_____**Massage Times:** Your massage sessions may last anywhere from a half hour to 2 hours. **Your massage hour will consist of 53 minutes of hands on treatment.** If you are running late to your appointment, your massage appointment may be shortened to assure that our next scheduled massage can start on time. If Complete Care is running behind, you will still receive the full length of the scheduled massage.

_____**Cancellation and No Show Policy:** I understand that I will be charged a **$30 Cancellation Fee** if I fail to notify Complete Care of a cancelation at least 1 business day before my scheduled appointment. Your appointment time is reserved for you. In order to better serve our patients we ask that you call our office at least 1 business day prior to your appointment. Please help us to help others.

_____**Returned Checks:** I understand that personal checks returned for non-sufficient funds may be charges a fee of $25. Balances must be handled by cash, credit card, or money order.

_____**Past Due Accounts:** I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter mailed. Please contact us before this if you would like to set up payment arrangements.

_____**Authorization for Disclosure of Information for Purposes of Service Reimbursement:** I hereby authorize Complete Care to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient's medical charges. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release Complete Care from all legal responsibility or liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that Complete Care has already taken action on my claim.

_____**On-Call Provider Services:** Please note that after hours call is available for all primary care urgent needs. Please be advised prescription refills will not be addressed after hours and that no opioids or benzodiazepines will be prescribed for urgent needs. Please also be advised that if you choose to utilize our after-hours call service and receive care via the phone by the medical provider, that there will be a $50.00 fee billed to your account. Thank you for your understanding.

CompleteCare Health Centers

_____**Assignment of Benefits:** I give lifetime authorization for payment of insurance benefits to Complete Care for any services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered. I hereby authorize this health care provider to release all information necessary to secure payment of benefits.

Please understand that the services you elect to participate in denote a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit, please contact our Billing Department as soon as possible. We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept the above policies.

_____ _____

Signature of Patient or Guardian **Date**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that Complete Care will use and disclose health information about me. I understand that my health information may include information both created and received by Complete Care, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information. I understand and agree that Complete Care may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I acknowledge, that at my request, Complete Care will provide me with a Copy of Complete Care's Notice of Privacy Practices.

_____ _____

Patient/Guardian/Guarantor Signature Date

_____ _____

Please Print Name DOB

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren) _____

[ ] Other_____

[ ] Information is not to be released to anyone.

This **Release of information** will remain in effect until terminated by me in writing.

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave a message asking me to return your call Other:_____

Informed Consent

I understand that health care providers cannot guarantee results of treatment. I know that each person reacts in a different way to treatments and procedures. Therefore, the results cannot be certain. I acknowledge that no guarantee of the outcome of the care I have requested has been made. I have ample opportunity to ask questions, and my questions have been answered to my satisfaction.

Chiropractic Care, Physical Therapy, Osteopathy, Massage Therapy, Nutrition Therapy:

Though chiropractic, physical therapy, osteopathy, massage therap6y and nutrition therapy treatments are usually beneficial and rarely cause any problems, I understand that, like many other forms of health care, there are some risks. These can include, but are not limited to; fractures, disc injuries, cerebral-vascular accidents, dislocations and sprain/strains. These complications are extremely rare occurrences.

_____ **Initial here to confirm that you have read and understand the Informed Consent.**