CASCADIA
HEALTH CARE, P.C.

Patient Registration

Last Name		First Name			M.I.
Address		City		State	Zip
Home Phone	Work Phone	Cell Phone/Pager		Spouse Work Phone	
Social Security No.	Birth Date	E-mail Address		Sex	Marital Status
Your Occupation		Employer			
Company Address		City		State	Zip
Spouse Name		Spouse Employer		Spouse Social Security No.	
Company Address		City		State	Zip
Who Referred You Here?				Relation to You	
Emergency Contact (Not Spouse)		Relation to You		Phone	
Person Responsible For Payment (Last Name, First, M.I.)				Relation to You	
Address	City	State	Zip	Phone	
Primary Insurance		Address			
City		State	Zip	Phone	
Name of Insured		Relation to You		Date of Birth	
Employer		I.D. Number		Group No.	
Secondary Insurance		Address			
City		State	Zip	Phone	
Name of Insured		Relation to You		Date of Birth	
Employer		I.D. Number		Group No.	

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for non-covered services and missed appointments. I also authorize the physician to release any information required for billing.

X_____ Date _____

PATIENT SIGNATURE (IF RELATIVE, STATE RELATIONSHIP)

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4916 NE St. Johns Road, Vancouver, WA 98661
(360) 694-4811

Medical Information

Date_____

Patient name _____

What are your most important health concerns? (please list in order of importance)

1. _____

2. _____

3. _____

4. _____

5. _____

Do you have any contagious diseases at this time? ☐ Yes ☐ No

If yes, what? _____

Are you currently receiving health care? ☐ Yes ☐ No

If yes, where and from whom? _____

What was the reason? _____

CURRENT MEDICATIONS (list ALL prescriptions, over-the-counter medications, vitamins, supplements, etc.)

_____

_____

_____

Are you hypersensitive or allergic to any foods or drugs? ☐ Yes ☐ No

If yes, which foods or drugs? _____

_____

What did you have for your last breakfast, lunch and dinner? _____

_____

Is this your typical food intake?_____

CONTINUED ON REVERSE

Past Medical History

BIRTH: Anything significant about your birth? _____

_____

CHILDHOOD ILLNESSES: Any surgery, accidents, emotional trauma or onset of chronic conditions? List in chronological order and indicate length of illness or injury.

Age 0 to 20 _____

_____

_____

_____

_____

Age 21 to 40 _____

_____

_____

_____

_____

Age 41 to Present _____

_____

_____

_____

_____

FAMILY HEALTH HISTORY: Describe health of family members (parents, grandparents, siblings, spouse, significant other). Include history of heart disease, cancer, or other disorders, in any.

_____

_____

_____

_____

_____

_____

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PAYMENT POLICY AND PATIENT AGREEMENT

Welcome to **Cascadia Healthcare P.C**. Please read and sign the following patient agreement. If you have any questions regarding our payment policy, please do not hesitate to ask your doctor or staff.

OUR PAYMENT POLICY: We require payment at time of service. There are exceptions, as follows:

1. **INSURED ACCIDENTS:** We require your claim and insurance information to bill your personal injury protection or other party's insurance. If medical expenses exceed policy limits, we will bill you or your private insurance.

2. **UNINSURED ACCIDENTS:** Pending settlement of your claim, we may agree to wait for payment of services rendered in your care. However, we require some payment (service fee less the professional component) at the time of service. Remember you are still responsible for payment, whether or not you collect from an at fault party. If we agree to wait for payment, you and your attorney must sign an assignment of insurance benefits to us.

3. **MEDICARE:** We bill Medicare as assigned providers and wait for payment; however you are responsible for payment of the Medicare deductible, subsequent co-payments, and all non covered services.

LATE FEES:

Unpaid bills for your treatment older than ninety (90) days will bear interest at the rate of 12% annually (1% per month) until paid. If we hire an attorney or collection agency to collect past due bills you will be liable for attorney, court, and collection costs.

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AUTHORIZATION TO RELEASE INFORMATION

I have read Cascadia Health Care's **PAYMENT POLICY AND PATIENT AGREEMENT** and agree to the stated terms. By signing below, I authorize Cascadia Health Care, P.C. to release information about my physical condition to any insurance company or my attorney in order to process my bill for payment.

_____
DATE

_____
PATIENT SIGNATURE

_____
PRINTED PATIENT'S NAME

_____
STREET ADDRESS

_____
CITY, STATE, ZIP CODE

By signing this document as a parent or guardian of a minor child about to be treated by the Clinic, I understand I am responsible for payment of the care my minor child receives at the Clinic.

_____
SIGNATURE OF PARENT/GUARDIAN

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Modified Function & Pain Rating Index
For use with Neck and/or Back Problems only

Patient Name _____ Date _____

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity				
0 no pain	1 mild pain	2 moderate pain	3 Severe pain	4 worst possible pain

2. Sleeping				
0 perfect sleep	1 mildly disturbed sleep	2 moderately disturbed sleep	3 greatly disturbed sleep	4 totally disturbed sleep

3. Personal Care (washing, dressing, etc)				
0 no pain; no restrictions	1 mild pain; no restrictions	2 moderate pain; need to go slowly	3 severe pain; need some assistance	4 severe pain; need 100% assistance

4. Sitting				
0 no pain comfortable	1 mild pain limiting	2 moderate pain restricting	3 moderate pain brief sit tolerated	4 severe pain cannot sit

5. Work

0	1	2	3	4
can do usual work; plus unlimited extra work	can do usual work; no extra work	can do 50% of usual work	can do 25% of usual work	cannot work

6. Recreation

0	1	2	3	4
can do all activities	can do most activities	can do some activities	can do a few activities	cannot do any activities

7. Frequency of Pain

0	1	2	3	4
no pain	occasional pain; 25% of the day	intermittent pain; 50% of the day	frequent pain; 75% of the day	constant pain; 100% of the day

8. Lifting

0	1	2	3	4
no pain with heavy weight	increased pain with heavy weight	increased pain with moderate weight	increased pain with light weight	increased pain with any weight

9. Walking

0	1	2	3	4
no pain; any distance	increased pain after 1 mile	increased pain after 1/2 mile	increased pain after 1/4 mile	increased pain with all walking

10. Standing

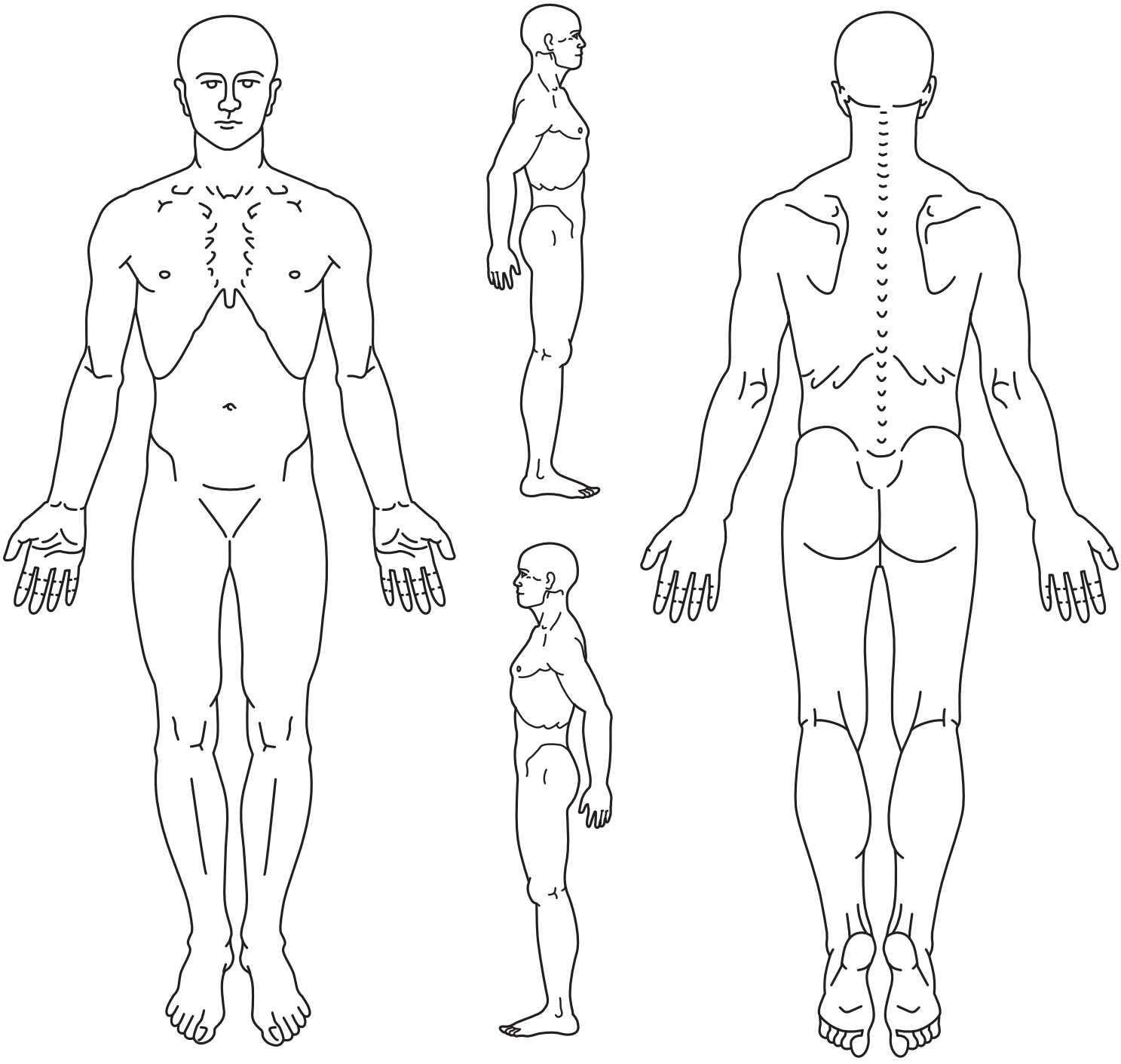
0	1	2	3	4
no pain after several hours	increaded pain after several hours	increased pain after 1 hour	increased pain after 1/2 hour	increased pain with any standing

Patient's Signature Date

PAIN DIAGRAM

Name_____ Date_____

Please mark all regions of pain or complaint on the body diagram below. You may do this any way you feel most comfortable, by circling, outlining, or shading the appropriate regions.



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Effective Date: April 14, 2003

Notice of Privacy Practices (short form)

Cascadia Health Care, P.C.

Health Insurance Portability and Accountability Act (HIPPA)

Cascadia Health Care, P.C. is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and Cascadia Health Care's duties with respect to your protected health information.

Cascadia Health Care, P.C. may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for health care bills, or to conduct health care operations.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information, including your demographic information, collected by us, or other health care providers, a health care clearinghouse, or an employer. This protected health information relates to your past, present, or future physical or mental health or condition, and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining and accounting go your disclosures of your medical information, requesting that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your right and our obligations under the law. You have the right to receive a copy of our most current NOTICE in effect. Please ask us and we will provide you with a copy.

We may revise our NOTICE. The Effective Date noted above indicates the date of the most current NOTICE in effect. If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact our office manager.

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Release of Patient Confidential Information/ Receipt of Notice of Privacy Practices

Patient Name_____ DOB _____

Address _____

City/State/Zip_____ Phone _____

I acknowledge receipt of the Notice of Privacy Practices.

Short / Long Form	Signature	Requested by	Date

Restrictions	Who Requested	Date Req.	Begin Date	End Date

Date	Information Disclosed	Purpose of Disclosure	Name/Address of Recipient	Initials