Hiro Chiropractic

Dr. Hiro Matsuno, D.C.
Hiro Matsuno, D.C. 1317 18th St. Springfield, OR 97477 (541)726-7151

Chiropractic Registration & History

PATIENT INFORMATION

Today's Date:_____ First Name:_____ Last Name:_____ Middle Initial:____

Sex:_____ Age: _____ Date of Birth: _____ Height:_____Weight:_____ Marital Status:_____

Occupation: _____ Employer:_____ Spouse's Name:_____ Number of Children:_____

Address: _____ City:_____ State:_____ Zip Code: _____

Home Phone:_____ Cell Phone: _____ Email:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone: _____Work Phone: _____

INSURANCE INFORMATION

Primary Insurance Carrier:_____ Phone Number:_____

Policy/ID Number:_____ Group Number:_____

Secondary Insurance Carrier:_____Phone Number:_____

Policy/ID Number:_____ Group Number:_____

AUTHORIZATION OR DISCLOSURE OF HEALTH INFORMATION

I authorize Hiro Chiropractic to use or disclose the following information hereinafter known as the "Medical Records" (check all that apply):☐Insurance benefits ☐Appointment times ☐Case credits/balances ☐Receipts ☐Other_____.

Hiro Chiropractic has my authorization to disclose Medical Records to the following party:_____ upon signing this form, & may also be disclosed with verbal consent with Hiro Chiropractic staff at a later date in time.

PATIENT CONDITION

Reason for visit:_____

Describe what Happened:_____

When did your symptoms begin?_____ Is it worse in the ☐ AM or ☐ PM ?

Is this condition progressively getting worse? Y / N / NA

Rate the severity of your pain on a scale from 1-10 (10 being severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐Sore ☐ Other:_____

How often do you have this pain?:_____

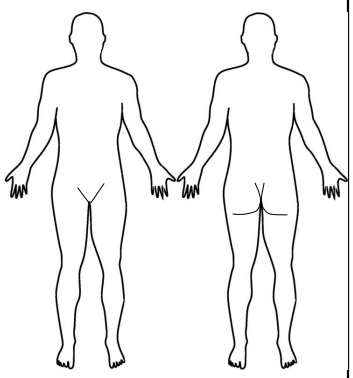
Is it constant or does it come and go?:_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐Recreation

Activities that are painful: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What makes it better?:_____

Mark an X on the picture where you are experiencing symptoms



FAMILY HEALTH HISTORY (insert relation ex: mother/father)

☐Heart Disease (_____) ☐Diabetes (_____) ☐Neurological Disease(_____)

☐Rheumatoid Arthritis (_____) ☐Cancer (_____) ☐Stroke (_____)

☐Autoimmune Disease(_____)

LIFE STYLE

How often do you sleep on your: ☐ Back (_____%) ☐ Stomach (_____%) ☐ Left side (_____%) ☐ Right side (_____%)

Activities/daily living/work exertion: ☐ Sitting (_____ hours/day) ☐ Light Labor ☐ Standing

☐ Heavy Labor ☐ Repetitive Activity ☐ Cardio/walking ☐ Strength/weight training ☐ Stretching

Do you smoke tobacco products? Y / N _____packs/day Do you drink alcohol? Y /N ____ drinks/week

Rate your posture from 1-10 by circling a number (10 being most ideal): 1 2 3 4 5 6 7 8 9 10

ACCIDENT INFORMATION

Is this visit related to an accident? Y / N Type of accident: ☐ Auto ☐ Work ☐ Home ☐Other:_____

HEALTH HISTORY

Have you ever seen a Chiropractor before? Y / N If yes, whom?_____

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Massage

☐ Acupuncture ☐ X-rays ☐ MRI ☐ Other:_____

Name of your local Medical Primary Care Physician:_____

Please check any of the following that you are having problems with (past: over 6 months ago)

Past	Current		Past	Current		Past	Current	
☐	☐	Headaches	☐	☐	Jaw pain/TMJ	☐	☐	Stomach trouble/ulcer
☐	☐	Loss of smell/taste	☐	☐	Pain in urination	☐	☐	Gall bladder trouble
☐	☐	Asthma	☐	☐	Difficulty starting/stopping urination	☐	☐	Bronchitis/emphysema
☐	☐	Twitching of face	☐	☐	Blood in urine	☐	☐	Hypo-thyroid problem
☐	☐	Depression	☐	☐	Menstrual cramps	☐	☐	Chest pain
☐	☐	Dizziness	☐	☐	Menstrual irregularity	☐	☐	Pins & Needles in arms/legs/hands
☐	☐	Loss of Balance	☐	☐	Diabetes			
☐	☐	Ringing in ears	☐	☐	Cancer _____	☐	☐	Intestinal problem
☐	☐	Osteoporosis	☐	☐	Sleeping problems	☐	☐	Allergy
☐	☐	Osteopenia	☐	☐	Swollen joint/ankle	☐	☐	Liver trouble/hepatitis
☐	☐	Constipation/Diarrhea	☐	☐	Cold feet/hands	☐	☐	High Blood Pressure
☐	☐	Kidney trouble	☐	☐	Whiplash	☐	☐	Low Blood Pressure
☐	☐	Bladder trouble	☐	☐	Heart attack	☐	☐	Other:_____
☐	☐	Blood clots	☐	☐	Stroke			

Fractures/Surgeries/Accidents in the past Year Any Complications?

_____ _____ _____

_____ _____ _____

Medications	Taking for....	Medications	Taking for....
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____

Signature: _____ **Date:** _____

Print Name:_____

"Thank you for taking the time to fill this out. We look forward to providing you with extraordinary service."
Dr. Hiro and the Hiro Chiropractic Team

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ASSIGNMENT AND RELEASE

Insurance Company: _____ I, the undersigned certify that I (or my dependent) have insurance coverage with the listed company and assign directly to Hiro Chiropractic, all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Initial: _____

FINANCIAL AGREEMENT

I have read and agree to the payment policies given to me (on the reverse side of this form). I understand that ultimately, I am responsible for payment of my account, and accounts with a past due balance (60 days from the date of service) may be subject to an additional collection and/or administrative fee and interest charges of 18% per month. I understand that there is a card processing fee (percentage posted at the front desk) that I am responsible for if I choose to pay with a credit or debit card.

Initial: _____

PREGNANCY RELEASE (MANDATORY for all Female Patients)

This is to certify that to the best of my knowledge I am not pregnant, and the above named doctor has my permission to perform an x-ray evaluation. I understand that x-ray can be hazardous to an unborn child.

Initial:_____ MANDATORY: Date of last menstrual period_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

(You May Refuse To Sign This Acknowledgement)
I have received/been offered a copy of this office's Notice of Privacy Practices.

Initial:_____

For office use only:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited the obtaining of the signature
- ☐ An emergency situation prevented obtaining the signature
- ☐ Other:_____

I have read and agree to all of the above:

Print Name (Legibly):_____

Patient's Signature: _____ Date:_____

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

Please print your name: _____ Relationship to patient:_____

Representative's Signature: _____ Date:_____

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Financial Agreement
We would like to welcome you to our office; we are committed to providing you with the best possible care. To familiarize you with the financial policies of our office, we would like to explain how your chiropractic bills will be handled. We accept cash, checks, Zelle, HSA/FSA cards, MasterCard and Visa. There is a card processing fee that affects all credit and debit card transactions. The fee amount is located at the front desk. Returned checks are subject to a $25 fee and accounts with a past due balance (60 days from the date of service) may be subject to additional collection and/or administrative fees and interest charges of 18% annually.

We must emphasize that as Chiropractic care providers, our relationship is with you, not any third party payer. If temporary financial problems arise, we encourage you to contact us promptly for assistance in the management of your account. Following are explanations for each type of case at our office. If you are unsure which applies best to you, please do not hesitate to ask.

Health Insurance
As a courtesy we may be able to bill your primary and secondary (if applicable) insurance plan. If your insurance company does not pay for the services rendered, the charges will be your responsibility. You are responsible for understanding your insurance benefit for each visit. Currently, we are considered in-network with Blue Cross Blue Shield, Medicare, and the VA. We are out-of-network with all other insurance companies and **do not submit claims to any insurance company we are out of network with EXCEPT for the following:**

- Pacific Source (non-OHP plans)
- Tribal Insurance companies

If you are an established patient, we will continue to bill your out-of-network carrier as a courtesy; however, we reserve the right to modify our billing procedures at any time. If you change your insurance to a different out-of-network carrier not listed above, we will no longer submit a claim on your behalf. We instead can provide you with the necessary information and documentation to self-submit your claim, allowing you to be reimbursed directly by your insurance company, if eligible. If we submit a claim to your insurance company and they defer the claim to an entity with which we are not contracted, we will discontinue billing your insurance for future services. **Copayment, coinsurance, payment for non-covered services, and any charges applied to your deductible are required at the time services are rendered.**

Non-insured
It is our policy to maintain your account on a current basis. Payment for services is due at time of visit. We offer discounted rates to those who sign up for a membership with ChiroHealthUSA. (We are unable to bill insurance if this discount is applied. We will gladly provide you resources so that you may submit to your insurance company on your own).

Motor Vehicle Accident
As a courtesy to you, if you were involved in an automobile collision, we will bill the driver's auto insurance company for services rendered in this office. All reasonable efforts will be made to collect from the insurance company, however, you will be personally responsible for payment of all services rendered and products supplied regardless of any settlement you may or may not receive.

Worker's Compensation
Under state regulated laws, your medical benefits should be covered for your work related injury. Before medical benefits can be paid, however, you need to do the following:

1. Report your injury to your supervisor immediately, if you have not already done so.
2. Complete an accident report (form 801) obtained from your employer
3. Complete a First Medical Report or Change of Attending Physician Report (form 827).

Chiropractic Physicians are authorized to treat workers compensation injuries for 60 days or 18 visits, whichever occurs first. If, at that point additional treatment is necessary, you will be referred to another physician for an evaluation.

By law, your industrial insurance carrier has 90 days from receipt of notification of your injury to accept or deny your claim. Your insurance carrier will notify you if they require you to change physicians due to an MCO contract. Until that time you may be treated by Dr. Matsuno. In the event that your claim is denied, you may appeal that decision. During an appeal process no fees are payable by you for medical services rendered in relation to your industrial injury. If an appeal is ruled not in your favor, your account automatically transfers to a non-insured account and **becomes payable by you.** Mileage traveled to and from your doctor appointments is reimbursable by your insurance carrier. Under certain conditions, meals and lodging may also be reimbursed.

Medicare
Hiro Chiropractic accepts assignment from Medicare. You will be asked to pay deductible and/or coinsurance amounts at the time of your visit. After a yearly deductible is met, Medicare will reimburse a percentage of approved spinal manipulation treatment. Medicare will *not* reimburse for any other fees including x-rays and examinations. Medicare, upon review, may limit the amount of Chiropractic treatments they will reimburse for certain conditions. If upon Medicare's review, certain treatment charges are not considered medically necessary, you will be personally responsible for these charges. The doctor will inform you prior to treatment if he has reason to believe that Medicare will not cover your spinal adjustment. This will allow you to make an informed decision about receiving services you may have to pay for out-of-pocket.

Canceled Appointments
If you are unable to keep your scheduled appointment, we ask that you notify the office 24 hours in advance so that we may allocate time to another patient that needs our care. You may call the office line (541-726-7151) and leave a message if you need to cancel your appointment after office hours.

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose to not receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related to one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events per one million persons a year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible compilation to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:_____

Parent of Guardian:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____

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Motor Vehicle Accident History Form

Name: _____ Today's Date: _____

Date of Accident: _____ Hour: _____am/pm Year/model of the car:_____

Location (street name, direction traveling, city, etc.)_____

Were you the driver? ☐ Yes ☐ No If you were a passenger, where were you seated?_____

Were you wearing a seatbelt? ☐ Yes ☐ No Did the seatbelt hold during the impact? ☐ Yes ☐ No

Was there a headrest on your seat? ☐ Yes ☐ No

Road conditions at the time of the accident: ☐ Wet ☐ Dry ☐ Icy ☐ Loose Gravel ☐ Other: _____

Visibility at the time of the accident: ☐ Clear ☐ Cloudy ☐ Foggy ☐ Other: _____

Were there any obstructions involved (example: blind corner, parked vehicles, etc?) _____

Did the police come to the accident scene? ☐ Yes ☐ No Who received a citation? _____

For what reason was the citation given? _____

Did any person involved in the accident require an ambulance? ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No Hospital Name: _____

While at the hospital, what tests, X-rays, etc, were done? _____

Were you given any special instructions and/or medications?_____

During the Accident

Were you aware of the approaching collision, or did it catch you by surprise? _____

Did you have time to brace yourself? ☐ Yes ☐ No

What was the position of your body and head at impact? (turned to the right / left / straight ahead, etc)?

_____

What position were you in following the impact?_____

Were you trying to grab or restrain anyone? Explain:_____

Was your foot on the break? ☐ Yes ☐ No Was your car stopped or rolling? _____

If you were moving, what was the estimated speed of your car: _____MPH Of the other vehicle(s):_____MPH

Was your car slowing down, gaining speed, at a steady rate, etc:_____

Did you lose consciousness (blackout) upon impact? ☐ Yes ☐ No If yes, for how long?_____

Did you see stars, bright white lights, or did you feel a blinding or explosive sensation to your head? ☐ Yes ☐ No

Were you struct from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked

Did your car strike the other(s) involved or did the other car strike yours? _____

Please describe to the best of your ability what happened during the accident: _____

_____

_____

_____

_____

Print Name: _____

What bleeding cuts did you receive during the accident?_____

Were you thrown about inside the vehicle? ☐ Yes ☐ No

On what part of the vehicle did the following body parts hit?

*Head:*_____ *Chest/Back:*_____

*Right/Left Shoulder:*_____ *Right/Left Knee:*_____

*Right/Left Hip:*_____ *Right/Left ankle, foot:*_____

*Right/Left arm, elbow, wrist, hand:*_____ *Other:*_____

Did you have any broken bones? ☐ Yes ☐ No _____

Did any objects in the car hit you? ☐ Yes ☐ No _____

What part of the vehicle broke during the accident?_____

Describe any pain or discomfort immediately following the accident:_____

_____

Describe any pain or discomfort later that same day: _____

_____

Describe any pain or discomfort the day after:_____

_____

Have you been in any previous auto accidents? List the year and briefly explain what happened and to what extent you were injured in each accident:

_____

_____

_____

Check any symptoms you have noticed *since* the accident:

☐ Headaches	☐ Chest Pain	☐ Depression	☐ Upset Stomach
☐ Neck Pain	☐ Dizziness	☐ Light Bothers Eyes	☐ Constipation
☐ Stiff Neck	Pins and Needles In:	☐ Fainting	☐ Cold Sweat
☐ Sleeping Problems	☐ Arms ☐ Legs	☐ Loss of Smell	☐ Fever
☐ Back Pain	Numbness in:	☐ Loss of Taste	☐ Other:
☐ Nervousness	☐ Fingers ☐ Toes	☐ Diarrhea	_____
☐ Tensions	☐ Shortness of Breath	☐ Cold Feet	_____
☐ Irritability	☐ Fatigue	☐ Cold Hands	_____

Is there any residual pain or discomfort from a previous accident that was bothering you before or that has worsened since this accident? Please explain:

_____

_____

_____

_____

_____

Print Name: _____

Insurance Information

Your insurance company: _____

Insurance company's address: _____

Insurance company's phone number: _____

Claim number: _____ Claim Rep: _____

Have you contacted an attorney concerning this new accident? ☐ Yes ☐ No

Attorney's name: _____ Phone Number: _____

On the drawing below, draw in where your vehicle was in relation to the other vehicle(s) involved

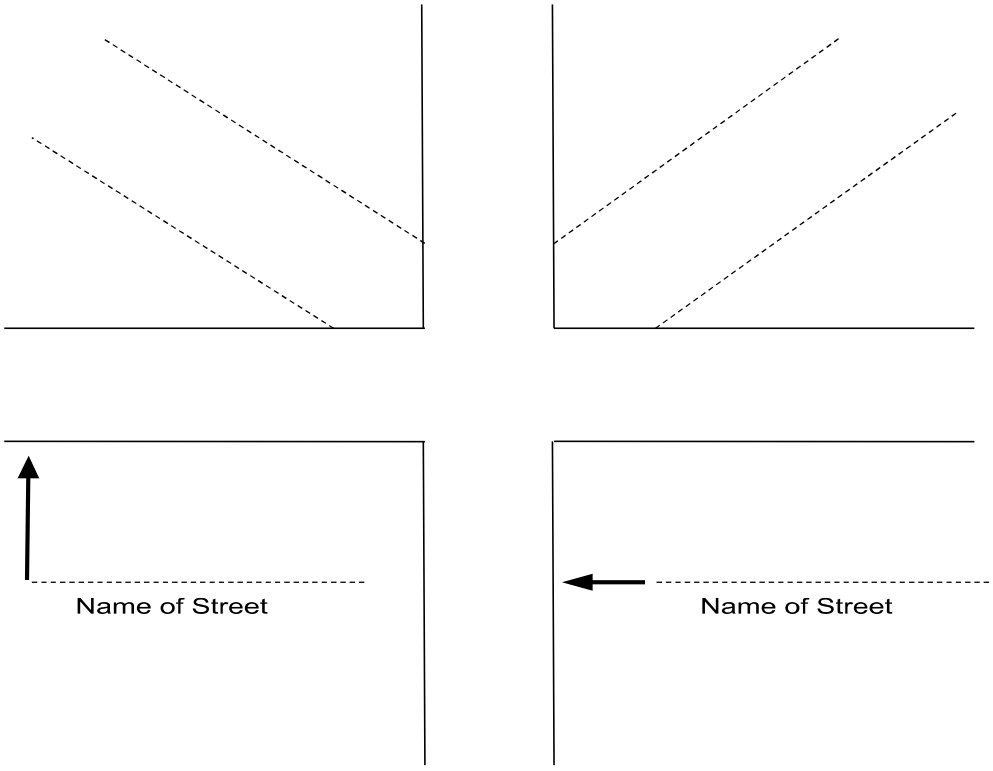
A = Your Vehicle

B = Other Vehicle

= Stop Sign

= Yield Sign

1. Draw signs or lights if present and where they were located
2. Use arrows to indicate the direction of travel for each vehicle involved



Signature: _____ Date: _____

HIRO CHIROPRACTIC

1317 18TH STREET • SPRINGFIELD, OREGON 97477 • (541) 726-7151
DR. HIRO MATSUNO, D.C.

MASSAGE CANCELLATION POLICY

Our Massage Therapists often have a waiting list of clients and No-Show or Last-Minute Cancellations greatly impact their scheduling as well as patient care who remain on the waiting list. Recognizing that we set aside the scheduled massage time just for you, have other clients to consider, and have to maintain a smoothly running business, we now find it necessary to charge for:

NO-SHOW APPOINTMENTS

Cancellation made within 24 hour notice

The Massage Therapists and Hiro Chiropractic Respectfully ask that you

Give a 24-hour notice of cancellation. Please Call 541-726-7151.

If we cannot answer, leave your information on our voicemail.

Appointments made within 24 hours of appointment time are automatically subject to cancellation fees.

Appointment/Cancellation Policy

Cancellation Fee: $45.00

*First No-Show or cancellation with under 24 hour notice is waived as a courtesy.

GIFT CERTIFICATES: Same policy applies.

LATE ARRIVAL: (up to 30 minutes): No fee is charged but your appointment will end at the scheduled time.

EMERGENCIES: We understand that emergencies and illnesses occur. If you have a fever, have been in the hospital, have been vomiting or have diarrhea within 24 hours of your scheduled appointment, please call us as soon as you can.

PLEASE NOTE: We will do our best to remind you of your appointment (we will call you the day before, or on Friday for Monday appointments). Given enough notice, we can usually fill most appointments. Even with less than 24- hour notice of your appointment, if we are successfully able to fill your spot with someone on our waiting list, the fee could be waived, so please give us as much notice as possible.

Signature: _____ Date:_____

Thank you,

Hiro Chiropractic