Gresham Spine Center & Kuns Chiropractic Clinic
Dr. Westley Kuns, D.C.
405 NE Division St., Gresham, OR 97030
Phone 503-661-0791 - Fax 503-661-1136

KUNS
CHIROPRACTIC CLINIC

PATIENT PAYMENT POLICY

We feel the patient's health needs are paramount; therefore, following a payment policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty. We require 25% of the first visit charges due on the first day of service. The balance of these charges may be made in payments over the next four weeks, unless we bill your insurance for payment. Properly documented Worker's Compensation and Auto Accident claims are not required to pay at this time if appropriate forms and liens are signed. Patients who have made payments with us need to make payments monthly. You will receive a statement with your charges itemized.

HEALTH INSURANCE

Today many insurance policies do cover chiropractic care. We will be happy to file your primary insurance claim for you and do everything we can to insure you receive proper reimbursement; however, we cannot take responsibility for what your insurance will or will not cover. If you have any questions about your coverage, you may call your Insurance Agent, HR Representative, or your Insurance Company directly to verify what your insurance will cover. If you do decide to verify your coverage, some of the questions we inquire about are regarding deductible (how much, when does it renew, and if any of it has been met), what percentage do they cover after deductible and co-pay or if preauthorization is needed. If it is an auto accident, or Worker's Compensation claim, the following information is important to obtain and document; time, date, what happened (example: slipped off of ladder and landed on back, struck arm on the way down, rear-ended in car, was in driver's seat), where it happened (example: in the walk-way at work, stopped at stop sign). If you are in an auto accident or on the job injury victim, we suggest you discuss your coverage with our billing person. We may have suggestions that will help you in this regard. You will be asked to authorize Kuns Chiropractic Clinic to furnish information regarding your case directly to your Insurance Company and to assign all benefits as a result of the claim.

APPOINTMENTS

In order to better serve our patients, we ask that you call if you are unable to make your appointment of if you will be late. Your appointment time is reserved for you. If you notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others.

EMERGENCY OR AFTER HOUR CALLS

In case of an emergency, you may contact the office for a special appointment any time during regular office hours. If you, a friend, or family member requires after hours or weekend assistance, you may call our office at 503-661-0791 and follow the directions to talk with our scheduling staff.

HIPPA

Our office follows standard rules in regard to privacy practices. By signing this form you understand this and understand that there is a posted copy in the office or you may request a copy of this policy at any time.

I have read Kuns Chiropractic Clinic policies and will honor them.

_____ _____

Patient Signature Date

Gresham Spine Center and Kuns Chiropractic Clinic
Dr. Westley M. Kuns, D.C.
405 NE Division St., Gresham, OR 97080
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KUNS
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CONFIDENTIAL PATIENT INTAKE FORM – PLEASE PRINT CLEARLY

Date: _____ Full Name: _____

Sex: _____ Date of Birth: ____/____/_____ Age: _____ SSN: _____-_____-_____
M or F Month / Day / Year

Mailing Address: _____ Apt. #: _____

City, State, Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

I would like to receive text message reminders of appointments :
_____ Yes _____ No
Cell phone CARRIER: _____

E-mail Address: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact: _____ Phone: _____

How did you hear about our office?: _____

Do you have any Insurance? ☐ Yes ☐ No Insurance Company _____

Insured Name: _____ Relation: _____

Identification Number: _____ Group Number: _____

I understand and agree that health and accident insurance policies are an arrangement between an Insurance Carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit payment. It is my understanding that my credit may be checked if Kuns Chiropractic Clinic extends credit to me. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctors at Kuns Chiropractic Clinic and whomever they may designate as their assistants to administer treatment as they deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify the above information is true and correct.

Patient (Parent or Guardian's) Signature: _____

Date: _____

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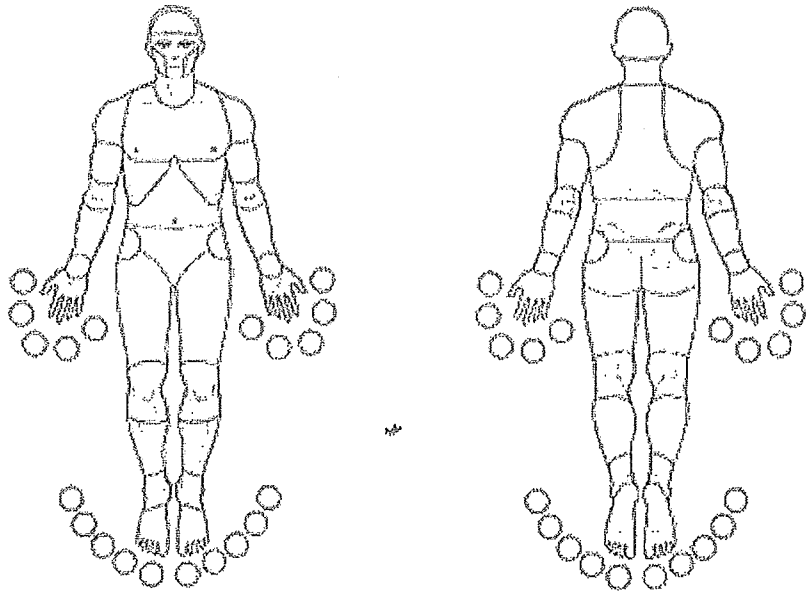
Patient History Form

Patient Name: _____ **Date:** _____

On the diagrams to the right, please mark where you are experiencing any symptoms:

Use the following as a guide:
P= Pain
T= Tingling
N = Numbness
B = Burning
W = Weakness



Is the pain constant? YES NO N/A **Is the numbness/tingling constant?** YES NO N/A

How long have you been suffering with your condition? _____

Have you had any problems like this in the past? _____

Has it been getting worse? YES NO **If yes, how long has it been getting worse?** _____

How would you describe the pain? Burning Ache Sharp Dull Deep Throbbing _____

_____

How would you rate your pain on a scale of 1 (best) to 10 (worst)?

Currently: 1 2 3 4 5 6 7 8 9 10 **At Its Best:** 1 2 3 4 5 6 7 8 9 10

On Average: 1 2 3 4 5 6 7 8 9 10 **At Its Worst:** 1 2 3 4 5 6 7 8 9 10

Did your problem come on gradually or suddenly? Gradual Sudden Not sure

Was there any type of injury that may have caused your problem? _____

_____

What aggravates your problem? Bending Lifting Twisting Turning Sitting Standing Walking

Sitting-to-Standing Laying Down Reading Computer Driving Getting in/out of vehicle

Other:

_____

Do any of these RELIEVE the pain? Heat Ice Stretching OTC Pain Meds Rest Nothing
Other:

Is your problem worse in the: Morning Afternoon Evening At Night During Sleep All the Same

Have you been told exactly what condition you have? _____

Have you tried any of the following?:			**Results of treatment: (circle one for each)**		
Muscle Relaxers (Prescription):	YES	NO	No Relief	Worse	Temporary Relief
Anti-Inflammatory Meds (Prescription):	YES	NO	No Relief	Worse	Temporary Relief
Pain Medications (Prescription):	YES	NO	No Relief	Worse	Temporary Relief
Physical Therapy:	YES	NO	No Relief	Worse	Temporary Relief
Chiropractic:	YES	NO	No Relief	Worse	Temporary Relief
Massage Therapy:	YES	NO	No Relief	Worse	Temporary Relief
Acupuncture:	YES	NO	No Relief	Worse	Temporary Relief
Injections (including epidurals):	YES	NO	No Relief	Worse	Temporary Relief
Spinal Surgery:	YES	NO	No Relief	Worse	Temporary Relief

Have you been told you need an injection? YES NO By whom? _____

Have you been told you need spinal surgery? YES NO By whom? _____

Have you ever had:

A spine fracture?	YES	NO							
Bone cancer?	YES	NO							
Bone infection, disease, or disorder?	YES	NO							
Abdominal aneurism?	YES	NO							
Night cramping?	YES	NO	----> Hands	Fingers	Calves	Feet	Toes	Right	
	Left								
Swelling?	YES	NO	----> Hands	Fingers	Legs	Ankles	Feet	Right	
	Left								

Do you have any muscle weakness in the arms or legs yet? YES NO Arms Legs Right Left

Do you have any muscle atrophy (loss of muscle tone) yet? YES NO Arms Legs Right Left

How is this affecting your life?

How serious do you consider this? _____

What do you think will happen if left untreated? _____

OSWESTRY PAIN QUESTIONNAIRE

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Please Read: This questionnaire is designed to enable us to understand how much pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may apply to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity
1. The pain comes and goes and is very mild.
2. The pain is mild and does not vary much.
3. The pain comes and goes and is moderate.
4. The pain is moderate and does not vary much.
5. The pain comes and goes and is severe.
6. The pain is severe and does not vary much.

Section 2 – Personal Care
1. I would not have to change my way of washing or dressing in order to avoid pain.
2. I do not normally change my way of washing or dressing even though it causes some pain.
3. Washing and dressing increases the pain, but I manage not to change my way of doing it.
4. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
5. Because of the pain, I am unable to do some washing and dressing without help.
6. Because of the pain, I am unable to do any washing or dressing without help.

Section 3 - Lifting
1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on the table).
5. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
6. I can only lift very light weights, at the most.

Section 4 - Walking
1. The pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than one mile.
3. Pain prevents me from walking more than a ½ mile.
4. Pain prevents me from walking more than a ¼ mile.
5. I can only walk while using a cane or on crutches.
6. I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
1. I can sit in any chair as long as I like without pain.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting more than one hour.
4. Pain prevents me from sitting more than a ½ hour.
5. Pain prevents me from sitting more than ten minutes.
6. Pain prevents me from sitting at all.

Section 6 - Standing
1. I can stand as long as I want without pain.
2. I have some pain while standing, but it does not increase with time.
3. I cannot stand for longer than one hour without increasing pain.
4. I cannot stand for long than a ½ hour without increasing pain.
5. I cannot stand for longer than ten minutes, without increasing pain.
6. I avoid standing, because it increases the pain immediately.

Section 7 - Sleeping
1. I get no pain in bed.
2. I get pain in bed, but it doesn't prevent me from sleeping well.
3. Because of my pain, my normal night's sleep is reduced by less than one-quarter.
4. Because of my pain, my normal night's sleep is reduced by less than one-half.
5. Because of my pain, my normal night's sleep is reduced by less than three-quarters.
6. Pain prevents me from sleeping at all.

Section 8 – Social Life
1. My social life is normal and gives me no pain.
2. My social life is normal, but increases the degree of my pain.
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, (e.g. dancing, etc.).
4. Pain has restricted my social life and I do not go out very often.
5. Pain has restricted my social life to my home.
6. I have hardly any social life because of the pain.

Section 9 - Traveling
1. I get no pain while traveling.
2. I get some pain while traveling, but none of my usual forms of travel will make it any worse.
3. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
4. I get extra pain while traveling which compels me to seek alternative forms of travel.
5. Pain restricts all forms of travel.
6. Pain prevents all forms of travel except those done lying down.

Section 10 – Changing Degree of Pain
1. My pain is rapidly getting better.
2. My pain fluctuates, but overall is definitely getting better.
3. My pain seems to be getting better, but improvement is slow at present.
4. My pain is neither getting better or worse.
5. My pain is gradually getting worse.
6. May pain is rapidly worsening.

Comments: _____

Patient Signature _____ Date: _____