Auto Accident Insurance Info

Southern Oregon Sports and Spine
Marc D. Heller, DC, PC, Matt Terreri, DC
Rachel Knight, DC
987 Siskiyou Blvd.
Ashland, OR 97520
541-482-0625

Today's date: _____ Date of Injury: _____
Name: _____Phone #:_____

_____

Patient Info

Auto Insurance Co. name: _____ Phone#: _____

Billing Address: _____

Claim #: _____ Policy #: _____

Adjustor: _____ Phone#: _____

Insured's info (if other than patient)

Name: _____Phone#: _____

Address: _____

Auto Insurance co. name: _____ Phone#: _____

Billing Address: _____

Claim #: _____ Policy #: _____

Adjustor: _____ Phone#: _____

Other Driver's Insurance Info (if another vehicle was involved)

Name: _____ Phone#: _____

Address: _____

Auto Insurance co. name: _____ Phone#: _____

Billing Address: _____

Claim #: _____ Policy #: _____

Adjustor: _____ Phone#: _____

I hereby authorize Southern Oregon Sports and Spine to furnish the insurance company/attorney with reports regarding examination, diagnosis, treatment, prognosis, etc. of myself in regard to this accident.

Signature: _____ Date: _____

Southern Oregon Sports & Spine
Marc Heller, DC, • Matt Terreri, DC, CCSP®
• Rachel Knight, DC
987 Siskiyou Blvd • Ashland, Oregon 97520
Phone: 541. 482. 0625 Fax: 541. 482.3364

VEHICLE COLLISION FORM

Name: _____ Today's Date:_____

General Facts of the Collision

Date of Collision: _____ Time of day of collision? _____

Address or location of collision: _____

Where were you seated in the vehicle? □ Driver □ Passenger – Where? _____

Your vehicle - Make/Model/Year? _____

Other vehicle - Make/Model/Year? _____

Site of impact? □ Head on □ Rear end □ Left side □ Right side □ Rollover □ Other _____

Your vehicle impacted with □ Another car □ Other object (explain) _____

Seat belt use: Were you wearing a □ Lap belt □ Shoulder belt □ Both □ No belt worn

Position of head restraint? □ Upper head □ Mid head □ Low - at neckline □ None □ Can't remember

Were your brakes: □ Applied □ Not Applied Was your vehicle: □ Stopped □ Rolling

During the Collision

Where you aware of impending collision? □ Yes □ No Where you braced for impact? □ Yes □ No

Where were your hands? □ Both hands on the steering wheel □ Left hand □ Right hand □ Don't Recall

What was your head position? □ Not turned □ Left □ Right □ Looking down □ Cannot recall

Body position at impact: □ Upright □ Leaning forward □ Turned to left □ Turned to right □ Cannot Recall

Did your airbag deploy? □ Yes □ No Did your seat break? □ Yes □ No

Did your body (including head) hit anything in the vehicle's interior? □ No □ Yes - If yes, then please explain

Did you lose consciousness? □ No □ Rendered unconscious □ Dazed; circumstances vague
□ Shaken up, but could function OK

Was any head apparel knocked off? □ None □ Hat □ Glasses □ Other_____

Approximate speed of your vehicle? _____ Approximate speed of other vehicle? _____

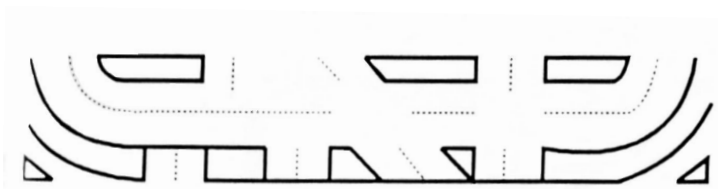
Road conditions at the time of collision: □ Clear □ Dry □ Rainy and wet □ Icy □ Dark □ Other_____

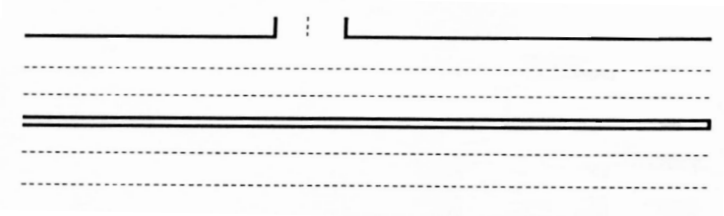
Indicate and state how the collision happened (note the vehicle you were in as "A")

_____

_____

_____





PLEASE TURN OVER AND COMPLETE SECOND SIDE

After the collision

Did the police come to the scene? □ No □ Yes, but no report was filed □ Yes and a report was filed □ Unknown

Where did you go? □ Home □ Work □ School □ Hospital - (which hospital?)_____

_____

After the collision my vehicle was □ Drivable □ Not drivable

Did you drive yourself? □ Yes □ No - Please explain _____

Estimated property value to your vehicle _____ □ Unknown

Estimated property value to other vehicle _____ □ Unknown

About You

Please check symptoms apparent since the collision

□ Headache	□ Nervousness	□ Numbness in feet/toes
□ Neck pain/stiffness	□ Shortness of breath	□ Numbness in hands/fingers
□ Eyes sensitive	□ Irritability	□ Cold feet
□ Dizziness	□ Depression	□ Cold hands
□ Fainting	□ Sleeping problems	□ Diarrhea
□ Ringing/buzzing in ears	□ Fatigue	□ Constipation
□ Loss of balance	□ Fever	□ Back pain
□ Loss of smell	□ Cold sweats	□ Chest pain
□ Loss of taste	□ Loss of memory	

Please list any symptoms not described above: (including any bruising or bleeding)

_____

_____

Were your symptoms noticed immediately after the collision or later on? (Please explain) _____

_____

_____

_____

Have you had any previous treatment for this incident/condition? □ No □ Yes (if yes, please list any and all treatment you have had. Please include doctor's names, approximate dates, and the types of therapy you have received).

_____

_____

_____

Who is your primary care physician? _____

Have you retained an attorney? □ No □ Yes Name _____

Where there any witnesses? □ No □ Yes Name(s) _____

_____ _____

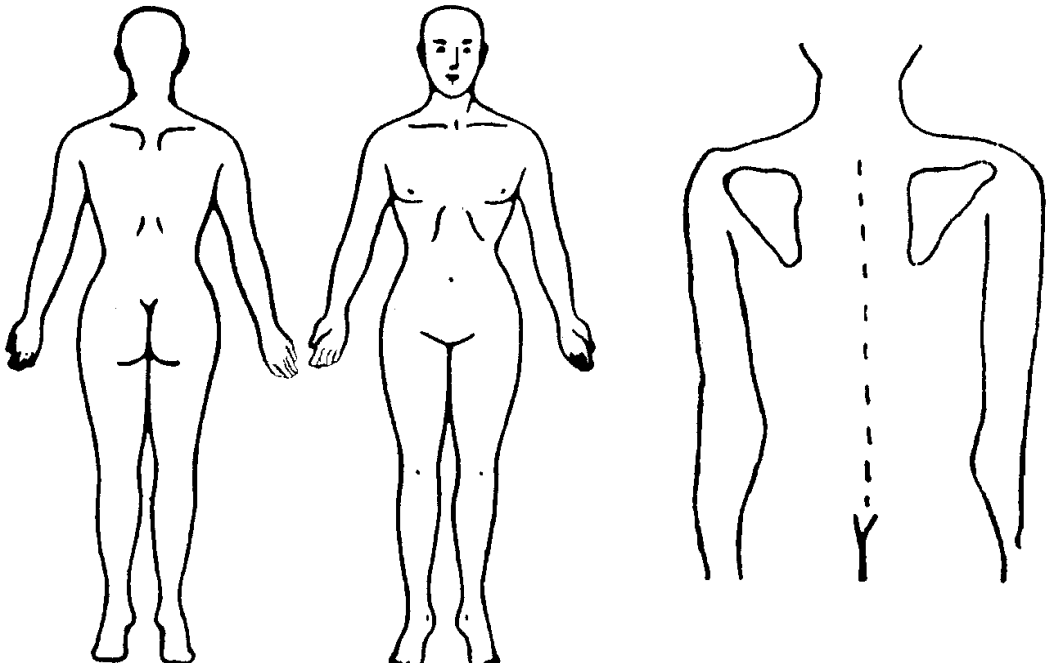
PATIENT'S SIGNATURE DATE

NAME _____ DATE _____

PATIENT PAIN PROFILE for Southern Oregon Sports and Spine 987 Siskiyou Blvd., Ashland, OR 97520

1. Please indicate where your pain is located. Indicate the appropriate location using the SYMBOL that best describes the discomfort you are presently experiencing.

Sharp & Stabbing = *
Dull & Achy = V
Pins & Needles = O
Numbness = /



2. Describe your symptoms and/or pain. (Where do you hurt?) _____

_____

3. Type of pain (Circle one or more)
   a. dull ache
   b. sharp
   c. shooting
   d. burning
   e. deep
   f. radiating
   g. numbness or tingling
   h. other _____

4. Please list any associated symptoms (i.e. leg pain, fatigue, irritability, headache, difficulty sleeping, etc.)

_____

5. Please mark your pain level on the 1 to 10 scale with a vertical line, with 0 being "no pain" and 10 being the maximum pain you can imagine.

	No Pain										**Intolerable**
NOW	0	1	2	3	4	5	6	7	8	9	10
AT WORST	0	1	2	3	4	5	6	7	8	9	10
AT BEST	0	1	2	3	4	5	6	7	8	9	10
AVERAGE	0	1	2	3	4	5	6	7	8	9	10

6. Did the problem start a) gradually _____ or b) suddenly _____?
7. Describe **how** it began. What started your pain—any trauma or unusual events? _____

_____

8. **When** did your pain begin? _____

9. What % of the time are you in pain? ____ 0-25% _____ 25-50%_____50-75%____ 75-100%

10. Is the problem constant _____ or off and on _____? How long does it last? _____

11. Is pain worse in morning? _____, late in the day _____, at night _____, or other_____

12. Compared to when it started, is your pain better _____ worse _____ or the same _____?

13. What other treatment have you had? _____

14. What makes the pain better (heat, ice, medication, laying down, moving, other)? _____

_____

14. What makes it worse (coughing, sitting, getting up from sitting, twisting, sneezing, etc.)

_____

15. How does this problem affect you, specifically your lifestyle, recreation, work, relationship, what can't you do comfortably any more? _____

_____

16. Have you had problems with this area before? _____ Describe them and how long you've had them. _____

_____

17. List any medication(s) you are now taking: _____

18. Please list any pertinent surgeries or hospitalizations:_____

19. Do you feel your work or lifestyle contribute to the problem? _____ If so, please describe.

_____

20. Are there any secondary problems you want to talk to the Doctor about? _____

_____

21. Any known birth defects or deformities? _____

22. Traumas (Give date of trauma and body part involved)

Vehicle Accidents _____

Work Injuries _____

Sports Injuries _____

Slip/Fall Injuries, Lifting Injuries _____

Concussions _____

Fractures/Dislocations _____

Birth Trauma _____

Childhood physical/sexual abuse _____

Other Injuries _____

Low Back Index

Form BI-100

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck and Upper Back Index

Form NI-100

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Southern Oregon Sports and Spine

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PATIENT INFORMATION FORM

TODAY'S DATE_____

PATIENT NAME_____PREFERRED NAME_____

ADDRESS_____CITY_____ST_____ZIP_____

MAILING ADDRESS (if different from above)

STREET OR PO BOX_____CITY_____ST_____ZIP_____

HOME PHONE# _____CELL PHONE#_____

EMAIL ADDRESS _____

BIRTH DATE _____AGE_____ HEIGHT_____WEIGHT_____

SS #_____

REFERRED BY _____

EMPLOYER'S NAME AND ADDRESS_____

YOUR PRIMARY HEALTHCARE PROVIDER _____PHONE#_____

EMERGENCY CONTACT_____PHONE#_____

INSURANCE _____ SUBSCRIBER'S NAME _____

SUBSCRIBERS DATE OF BIRTH (IF NOT PATIENT) _____

SPOUSE'S NAME_____WORK PHONE#_____

SPOUSE'S EMPLOYER_____ADDRESS_____

SPOUSE'S BIRTHDATE_____

WHO IS RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING TODAY BY CASH _____ CHECK _____ CREDIT CARD _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature
*Date*_____ _____
Parent (if minor) *Date*

SOUTHERN OREGON SPORTS & SPINE MEDICAL HISTORY
REVIEW OF SYSTEMS FORM

DATE:_____NAME:_____DATE OF BIRTH_____
___MARRIED ___SINGLE ___DIVORCED ___WIDOWED; OCCUPATION:_____
NO. OF CHILDREN:___ TOBACCO USE: YES/NO HOW MUCH?____/DAY HOW LONG? DATE QUIT_____
ALCOHOL USE: YES/NO HOW MUCH?_____/DAY CAFFEINE (COFFEE, TEA, COLAS) PER DAY_____

REVIEW OF SYSTEMS-PLEASE CIRCLE EACH ITEM OR "NONE" AS THEY RELATE TO YOUR HEALTH

CONSTITUTIONAL NONE
Fatigue
Fever

MUSCULOSKELETAL NONE
Osteoporosis
Arthritis
Joint Pain
Other: _____

NEUROLOGICAL NONE
Anxiety
Headaches
Dizziness/Vertigo
Memory Loss
Numbness
Seizures
Other: _____

EYES NONE
Glasses/Contacts
Double Vision
Cataracts
Other:_____

EAR, NOSE, THROAT NONE
Difficulty Hearing
Ringing in Ears
Sinus Trouble
Other: _____

ALLERGIES/IMMUNE NONE
Hives/Eczema
Hay Fever
Other:_____

CARDIOVASCULAR NONE
Chest Pain
Shortness of Breath
Stroke
Murmur
Palpitations
Heart Disease
High Cholesterol
High Blood Pressure
Fainting Spells
Dizziness
Difficulty Laying Flat
Swelling Ankles
Other: _____

RESPIRATORY NONE
Asthma
Cough
Coughing Blood
Wheezing
Chills
Other: _____

ENDOCRINE NONE
Diabetes
Weight Loss/Gain
Loss of Hair
Heat/Cold Intolerance
Other: _____

MENTAL NONE
Depression
Alcohol/Substance Abuse
Other: _____

GASTROINTESTINAL NONE
Heartburn/Reflux
Nausea/Vomiting
Constipation
Diarrhea
Black/Bloody Stools
Changes In BM
Abdominal Pain
Jaundice (yellowish skin)
Other: _____

HEMATOLOGY/LYMPH NONE
Bruise Easy
Gums Bleed Easy
Enlarged Glands
Other: _____

SKIN NONE
Rash/Sores
Itching/Burning
Dryness
Other: _____

GENITOURINARY NONE
Burning/Frequency
Blood In Urine
Incontinence
Other:_____

OTHER KNOWN CONDITIONS
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES AS BEST YOU CAN)
_____
_____
_____

PAST OR PRESENT ILLNESSESS OF YOUR FAMILY: (CIRCLE ALL THAT APPLY)

ALCOHOLISM	HIGH BLOOD PRESSURE	OSTEOPOROSIS
ANEMIA	KIDNEY DISEASE	PHLEBITIS
ASTHMA	LIVER DISEASE	RHEUMATIC ARTHRITIS
CANCER/TUMOR	HEPATITIS	STROKE
DIABETES	HIGH CHOLESTEROL	THYROID DISEASE
DEPRESSION	HIV/IMMUNE DISEASE	TUBERCULOSIS / TB
EPILEPSY/SEIZURES	LUNG DISEASE	ULCER IN GI TRACT
GLAUCOMA	MENTAL ILLNESS	OTHER: _____
HEART DISEASE	OSTEOARTHRITIS	

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Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Marc Heller, Dr. Matthew Terreri, and Dr. Rachel Knight, hereafter to be referred to in this document as Southern Oregon Sports and Spine, for all chiropractic services, rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Southern Oregon Sports and Spine to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing.

I have requested chiropractic services from Southern Oregon Sports and Spine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered, unless other arrangements have been made in advance with our business manager, and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your or get more information about it by contacting the office manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature	Date	Time

Printed name	Relationship (parent, legal guardian, personal Representative)

This form will be retained in your medical record.

Southern Oregon Sports and Spine
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987 Siskiyou Blvd.
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What to expect after your first adjustment

Most of the time, you will feel better after your first treatment. You probably won't feel 100% but you may have a greater sense of ease and ability to move more freely with decreased pain. If you have been in pain for longer than a few days then it usually takes longer to get relief.

Keep in mind your body is adapting to new positioning, alignment and freedom. The first night or the next day after the first treatment symptoms that you came in with may increase - occasionally dramatically. This reaction happens to about 30% of our patients and it is hard to predict to whom this will happen. Within 24-48 hours, you will usually start to feel better.

If you do have a negative reaction to the first treatment and it is not diminishing by the end of the second day, please call us. We should see you as soon as possible if the pain is not diminishing. It is often simple to resolve this type of continuing reaction with the right treatment.

Even if you feel better, it is important to use common sense, do your exercises and choose the right level of activity to support your healing. In other words, don't over do it! Small movements are generally better than none, and we will teach you correct movement/exercise patterns during your visits here.

If you are still hurting, ice is almost always safe and often gives good temporary relief. Use ice for 15-20 minutes, at least until the area becomes numb. You can use ice frequently up to once per hour. You can use an ice gel pack, a sack of frozen peas or corn, a zip-lock bag filled with ice cubes or ice cubes and water. Try to keep the rest of your body warm and comfortable while you are icing. The coldness may initially burn or hurt but should help block the pain by the time you are numb. Use a thin layer of cotton between your skin and the ice bag to prevent an ice burn to your skin.

Please let us know before you leave the office if you are feeling worse than when you came in.

MARC HELLER, DC; MATT TERRERI, DC ; RACHEL KNIGHT, DC

I have read and understand the above information.

_____ _____

Signature Date

FUTURE APPT. NOTIFICATION METHOD

TO OUR PATIENTS:

WE CAN NOW NOTIFY YOU OF YOUR UPCOMING APPOINTMENTS VIA TEXT MESSAGING OR EMAIL RATHER THAN A PHONE CALL.

PLEASE INDICATE YOUR PREFERENCE ALONG WITH YOUR CELL PHONE NUMBER AND CELL PHONE PROVIDER (CELL PHONE NETWORK) AND/OR EMAIL ADDRESS.

THANKS!

NAME_____

I WOULD PREFER TO RECEIVE MESSAGES BY:

☐ TEXT MESSAGE.

MY CELL PHONE NUMBER IS:_____

MY CELL PHONE PROVIDER IS:_____

YOUR CELL PHONE NETWORK/PROVIDER WILL BE ONE OF THE FOLLOWING:
AT&T, BOOST MOBILE, CRICKET, METRO PCS, NEXTEL, SPRINT, T-MOBILE,
US CELLULAR, VERIZON

☐ EMAIL MESSAGE.

MY EMAIL ADDRESS IS:_____

Southern Oregon Sports and Spine

Marc Heller, D.C., Matthew Terreri, D.C., Rachel Knight, D.C.
987 Siskiyou Blvd, Ashland, OR 97520 541-482-0625

Patient Informed Consent to Treatment

Patient Name: _____

I hereby request and consent to the performance of chiropractic adjustments and other therapeutic procedures by Marc Heller, D.C., Matthew Terreri, D.C., Rachel Knight, D.C. and/or the staff of licensed professionals of Southern Oregon Sports and Spine and Marc Heller, P.C. who now, or in the future, treat me in this office.

The most common side-effect of chiropractic treatment is short-term (12-36 hours) soreness. The more severe risks are rare.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some rare risks to treatment, including but not limited to: sprains and strains, fractures, disc injuries, dislocations, general aggravations of inflammatory conditions, allergic responses, and strokes. Our office specializes in low-force techniques and conservative approaches to minimize risks and maximize results. The doctor will discuss with you the nature and purpose of chiropractic adjustments and other procedures. The doctor will perform an exam in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise professional judgment during the course of the procedure which the doctor feels at the time, based upon facts as then known, is in my best interest. Finally, I understand that the chiropractors and staff at Southern Oregon Sports and Spine give no guarantee or assurance as to the results of his/her procedures.

Other treatment options for your condition may include: self-administered, over-the-counter analgesics; medical care which could include prescription medicine, physical therapy, surgery or hospitalization. Our office does not recommend ignoring symptoms. There are risks if you do not get treated.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the recommended procedures. I intend this document to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or guardian's signature: _____ Date: _____