



Dr. Leslie B. Berman, PC
Total Wellness & Chiropractic

New Patient Information

Please fully complete the following form with your most current information. For our patients with insurance, please present insurance card(s) when you submit this form. Thank you for your assistance.

Patient name: (first) _____ (m.i.) _____ (last) _____
DOB: _____ Marital status: (circle one) Married Single Divorced Widowed Partner
SS#: _____ Sex: M F Primary physician: _____
Address: _____ City: _____ State: ____ Zip: _____
Home phone: _____ Cell: _____ E-mail: _____
Family members: (names and birth dates) _____
Employer: _____ Address: _____ Phone: _____
In case of emergency, please contact: _____ Phone: _____
Source of referral: _____ Was this easily obtained: (circle one) Yes No

Insurance information

Primary insurance: _____ ID#: _____
Address: _____ Phone: _____
Effective date: _____ Policy holder name: _____ Group #: _____
DOB: _____ SS#: _____ Relationship to patient: _____
Secondary insurance: _____ ID#: _____
Address: _____ Phone: _____
Effective date: _____ Policy holder name: _____ Group #: _____
DOB: _____ SS#: _____ Relationship to patient: _____

I authorize the release of any medical or insurance information necessary to submit insurance claim(s). I request payment of insurance benefits to be made directly to Leslie Berman, PC. I understand that I am financially responsible for charges under this agreement and hereby guarantee payment for the above named patient. Further, I agree to pay any deductible and/or co-payments at the time of service. I agree to make full payment for any supplements and products at time of purchase.

Signature _____ Date _____

(If minor patient, please provide the signature of parent or guardian.)

Patient Name _____

Birthdate _____

To help us provide you the best healthcare possible, please fill out both sides of this form completely. This is a confidential record of your medical history and will not be used outside of this medical practice. If you are uncertain about any information, please discuss this with your attending physician.

Today's date _____

Date of last physical exam _____

Place of birth _____

Name of doctor _____

Highest level of education _____

List all serious illnesses, operations and hospitalizations you have experienced. Indicate the year these occurred. _____

Occupation _____

Previous occupation _____

Marital status _____

Hobbies _____

Exercise practice _____

List all medicines you are currently taking, including non-prescription drugs or medications. _____

Recreation practice _____

Smoking (type & amount) _____

If former smoker, date quit _____

Alcohol (type & amount) _____

Caffeine (type & amount) _____

Other drugs (type & amount) _____

Describe all serious accidents and injuries. Be sure to include any head injuries, fractures, broken bones, tears or strains. _____

Usual weight _____

Date of last dental exam _____

Please list all allergies (food, drugs, environmental) _____

Have you ever had the following:

Circle 'no' or 'yes'; leave blank if uncertain.

Measles No Yes
Mumps No Yes
Chickenpox No Yes
Whooping Cough No Yes
Scarlet Fever No Yes
Diphtheria No Yes
Smallpox No Yes
Pneumonia No Yes
Rheumatic Fever No Yes
Heart Disease No Yes
Arthritis No Yes
Venereal Disease No Yes
Anemia No Yes
Bladder Infections No Yes
Epilepsy No Yes
Ear Infections No Yes

Migrain Headaches No Yes
Tuberculosis No Yes
Diabetes No Yes
Cancer No Yes
Polio No Yes
Glaucoma No Yes
Hernia No Yes
Blood/Plasma Transfusion No Yes
Back Trouble No Yes
High/Low Blood Pressure No Yes
Hemorrhoids No Yes
Asthma No Yes
Abnormal Lab Results No Yes
Repeated Antibiotic Use No Yes
Hives/Eczema No Yes
AIDS/HIV No Yes

Infectious Mono No Yes
Bronchitis No Yes
Mitral Valve Prolapse No Yes
Stroke No Yes
Hepatitis No Yes
Ulcer No Yes
Kidney Disease No Yes
Thyroid Disease No Yes
Bleeding Tendency No Yes
Date of last Chest X-ray _____
List Other Diseases _____

Has any blood relative ever had any of the following:

(Circle 'no' or 'yes'; leave blank if uncertain)

Cancer No Yes Relationship _____
Tuberculosis No Yes Relationship _____
Diabetes No Yes Relationship _____
Heart Disease No Yes Relationship _____
High Blood Press. No Yes Relationship _____
Stroke No Yes Relationship _____
Epilepsy No Yes Relationship _____
Allergies No Yes Relationship _____
Anemia No Yes Relationship _____
Chronic Lung Disease No Yes Relationship _____
Drug/Alcohol Problem No Yes Relationship _____
Mental Illness No Yes Relationship _____

Leukemia No Yes Relationship _____
Migraine Headaches . No Yes Relationship _____
Obesity No Yes Relationship _____
Thyroid Disease No Yes Relationship _____
Ulcer No Yes Relationship _____
Depression No Yes Relationship _____
High Cholesterol No Yes Relationship _____
Kidney Disease No Yes Relationship _____
Glaucoma No Yes Relationship _____
Gout No Yes Relationship _____
List other Diseases _____

Do you have or have you had in the past year:

Circle 'no' or 'yes'; leave blank if uncertain.

- Muscle weakness No Yes
- Fatigue No Yes
- Recent weight changes No Yes
- Changes in appetite No Yes
- Heat/Cold sensitivity No Yes
- Night sweats/Hot flashes No Yes
- Skin problems No Yes
- Hair/Nail changes No Yes
- Headaches No Yes
- Easy bleeding/bruising No Yes
- Dark circles/bags under eyes No Yes
- Double/blurred vision No Yes
- Eye fatigue No Yes
- Painful/itchy eyes No Yes
- Glasses/contacts No Yes
- Ringing in ears No Yes
- Other ear problems No Yes
- Frequent colds/cough No Yes
- Sinus trouble No Yes
- Sore throat/gums No Yes
- Allergies No Yes
- Body weight concerns No Yes
- Hair loss No Yes
- Cravings No Yes
- Fluid retention No Yes

- Slurred speech No Yes
- Yeast/Fungal infections No Yes
- Chest pain/discomfort No Yes
- Difficulty breathing No Yes
- Palpitations No Yes
- Leg cramps No Yes
- Difficulty swallowing No Yes
- Heartburn No Yes
- Frequent belching No Yes
- Abdominal cramping No Yes
- Nausea No Yes
- Vomiting No Yes
- Chronic diarrhea No Yes
- Chronic constipation No Yes
- Problems with urination No Yes
- Lack of sex drive No Yes
- Hemorrhoids No Yes
- Tendinitis No Yes
- If so, where _____
- Need more sleep than usual No Yes
- Swollen glands No Yes
- Canker sores No Yes
- Jaw problems No Yes
- Joint pain/stiffness/swelling No Yes

- Tingling/numbness No Yes
- Muscle cramps/spasms No Yes
- Sleep difficulty No Yes
- Snoring No Yes
- Seizures No Yes
- Depression/anxiety No Yes
- Memory loss No Yes
- Poor concentration No Yes
- Dizziness/fainting spells No Yes

Men Only:

- Prostate enlargement No Yes
- Discharge from penis No Yes
- Pain/lump in testicles No Yes
- Erectile dysfunction No Yes
- Genital itch No Yes

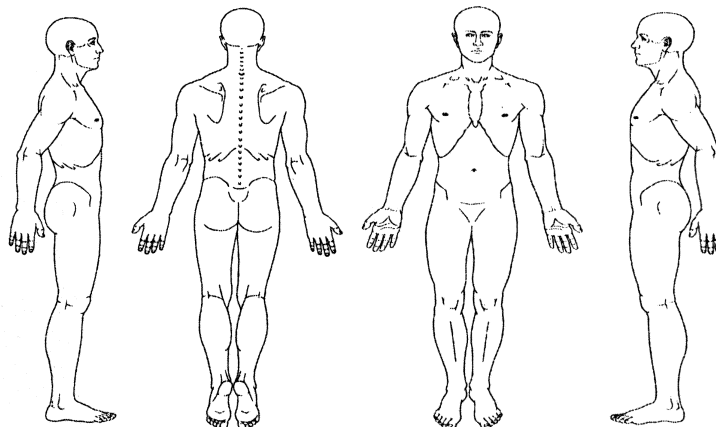
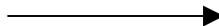
Women Only:

- PMS No Yes
- Pain with intercourse No Yes
- Vaginal area itching No Yes
- Menstrual difficulties No Yes
- Date of last period _____
- Date of last pelvic exam _____
- Type of birth control used _____
- Number of pregnancies _____

Regarding your body pain, mark all that apply.

- | | |
|-------------------------------------|---------------------------------------|
| Description | Frequency |
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Dull Pain | <input type="checkbox"/> Frequent |
| <input type="checkbox"/> Ache | <input type="checkbox"/> Occasional |
| <input type="checkbox"/> Weak | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Throbbing | |
| <input type="checkbox"/> Numb | |
| <input type="checkbox"/> Shooting | |
| <input type="checkbox"/> Gripping | |
| <input type="checkbox"/> Burning | |
| <input type="checkbox"/> Tingling | |

Mark the picture where you have pain or any other symptoms.



Indicate the intensity of your pain at its lowest and highest level. Circle. No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

- Your symptoms are..... decreasing not changing increasing
- Symptoms are worse..... in the morning in the afternoon at night
- Symptoms increase over the course of the day stay the same all day
- What makes your pain better..... Nothing Lying down Walking Standing Sitting Exercise Inactivity
- What makes your pain worse Nothing Lying down Walking Standing Sitting Exercise Inactivity

When did your problem begin? _____ Describe how your problem began. _____

- Have you been treated *for this episode*? Yes No
- If yes, what kind of treatment(s)? _____
- Are you currently being treated? Yes No
- If yes, what kind of treatment(s)? _____
- Have you been treated for this in the past? Yes No
- If yes, what kind of treatment(s)? _____

- How would you rate your general stress level? Circle. No stress 1 2 3 4 5 6 7 8 9 10 Extreme stress
- How would you rate your general activity level? Circle. No activity 1 2 3 4 5 6 7 8 9 10 Extreme activity
- What is your physical activity level at work? Circle. No activity 1 2 3 4 5 6 7 8 9 10 Extreme activity

Aside from your chief complaint, what is keeping you from feeling your best? _____

Signature _____

Date _____



Dr. Leslie B. Berman, PC
Total Wellness & Chiropractic

Consent for Treatment and Advisement of Financial Policy

Patient Name: _____ DOB: _____

Consent for Treatment

The undersigned hereby consents to all treatment, diagnostic procedures, or other that is deemed necessary or advisable by the doctor, the doctor's associates and assistants in consult with the patient (or undersigned if the patient is a minor).

Insurance Claims

PATIENT INSURANCE IS NOT A GUARANTEE OF PAYMENT FOR SERVICES. Our facility cannot accept the responsibility of collecting your insurance claims or negotiating a settlement on a disputed claim. All fees and expenses incurred by the patient are the sole responsibility of the undersigned. PAYMENT FOR GOODS AND SERVICES NOT BILLABLE TO INSURANCE WILL BE EXPECTED AT THE TIME OF SERVICE. A partial list of typical items: electrodes, hot/cold packs, supplements, pillows, orthotics, tens units and braces. As a service to patients, we will complete and submit insurance claims. Regardless of any outstanding insurance claims, FULL PAYMENT IS DUE WITHIN 60 DAYS.

Discounts and Credit Policy

A 15% discount is offered for any medical services, excluding supplements and equipment, that are paid in full at the time of the visit. For our patients with insurance, we are happy to provide you with a receipt and any necessary information for you to file your own insurance claim directly with your insurance provider. This discount cannot be used in conjunction with any other discounts or special offers. Unless an acceptable payment plan has been arranged prior to the visit, full payment must be made within 60 days. Balances over 60 days old are subject to a 1.5% finance charge. Should it become necessary to turn the patient's account over to a collection agency, the undersigned agrees to pay reasonable attorney's fees and collection expenses incurred by this facility. Any returned checks are subject to a \$25.00 insufficient funds charge.

Assignment of Insurance Benefits

The undersigned authorizes payment of all insurance benefits otherwise payable to the patient for medical expenses to be made directly to Dr. Leslie Berman, PC. The undersigned accepts financial responsibility to this facility for any charges not covered by insurance benefits and agrees to payment of all charges within the limits of this credit policy, regardless of insurance coverage. A reproduction of this authorization shall be considered as effective and valid as the original.

Insurance Release

The undersigned hereby authorizes Dr. Leslie B. Berman, PC, and this facility to furnish relevant insurance organizations all information that said insurance organization may request and/or require concerning the patient's illness/injury and treatment, including all psychiatric, drug alcohol abuse, acquired immune deficiency syndrome, thus releasing Dr. Berman, PC, and this facility from any liability for furnishing such information.

Signature: _____ Date: _____

Relationship to patient: _____ SS#: _____

DR. LESLIE BETH BERMAN, P.C.

Chiropractic Physician

2438 N.W. Professional Drive, Corvallis, Oregon 97330 Phone: 541-754-0054

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information, from April 14, 2003 forward. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location your request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means, or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information.

Contact Officer: Sherry Kirkpatrick

Telephone: 541-754-0054 Fax: 541-754-0363 Email: drberman@quik.com

Address: 2438 N.W. Professional Drive, Corvallis, Oregon 97330

I acknowledge that I have been provided a copy of the above Privacy Practices statement.

Printed Name: _____

Signature: _____

Date: _____

For Office Use Only

- The patient signature above acknowledges receipt of a copy of Dr. Berman’s Privacy Practices.
- We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
 - Individual refused to sign.
 - Communication barriers prohibited obtaining the acknowledgement.
 - An emergency situation prevented us fro obtaining acknowledgement
 - Other