Solutions Chiropractic LLC
Dr. Jim Bowman DC
www.SolutionsChiroporactic.net

1009 NW Hoyt St. #100
Portland, OR 97209
503.964.9096 (f) 503.212.0316

Solutions Chiropractic: COVID-19 Safety Procedures

In-person treatment likely involves some
INCREASED RISK OF EXPOSURE (for you and me).

Here are some of the safety measures we propose to help mitigate that increased risk:

- Every patient will be screened for symptoms of active infection prior to entry, including:
  a. Fever of **100.4** or above using an instant, touchless temperature scanner.
  b. Have you or any member of your household had **contact with anyone who has tested positive for COVID-19** in the last 14 days?
  c. Do you have the following symptoms of COVID-19? **Dry Cough, Shortness of Breath, Difficulty Breathing.**
  d. Do you have at least 2 of the following symptoms? **Fatigue, Fever, Chills, Nausea, Runny Nose, Sore Throat, Headache, Diminished Sense of Taste or Smell, Dermatological Changes, Diarrhea, Headache, Muscle/Joint Aches.**

- If you have symptoms, you will not be allowed into the clinic at this time. You will not be charged a cancellation fee.

- Only scheduled patients will be allowed into the clinic. No person (adult or child) may accompany a patient into the clinic.

- Patients will be asked to sign a one-time COVID-19 waiver before they enter the clinic. A copy is included below for you to read. We will have an identical, printed copy available for you to sign at the clinic.

- I will let you into the clinic at your scheduled appointment time. Early arrivals will need to wait outside to limit exposure between patients.

- Please bring a tight-fitting mask. We will have hand sanitizer available. Also, a sanitized restroom will be available.

- Arrangements for payment will be made over the phone or via secure website.

- I will be treating with gloves, face mask, protective eye wear and a clean shirt for each patient visit.

- I advise you to wash your hands, face, and clothes after leaving the clinic.

- Between every patient, all touch points in the entire clinic (from the front door to the restrooms) will be sanitized.

- Only one practitioner will have patients in shared common space on any given day.

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Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus (COVID-19) has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and other measures to attempt to limit the spread of infection.
Solutions Chiropractic LLC ("Solutions") has put in place preventative measures to reduce the spread of COVID-19; however, Solutions cannot guarantee that you will not become infected with COVID-19 from exposure at the treatment location. Further, in-person treatment with Solutions could increase your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by attending in-person treatment with Solutions and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to Solutions.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my in-person treatment with Solutions. On my behalf, and on behalf of my heirs and assigns, I hereby release, covenant not to sue, discharge, and hold harmless Solutions, their employees, members, agents, and representatives, of and from all claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating to exposure to or infection with COVID-19. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Solutions, their employees, members, agents, and representatives, whether a COVID-19 infection occurs before, during, or after in-person treatment with Solutions.

____
Signature of Patient:

____
Date:

____
Print Name of Patient:

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Patient Initial Intake

Name: ______________________________ DOB: ___/___/______ Date: ___/___ /______

Describe your symptoms: ______________________________

Describe any activities affected by your symptoms: ____________

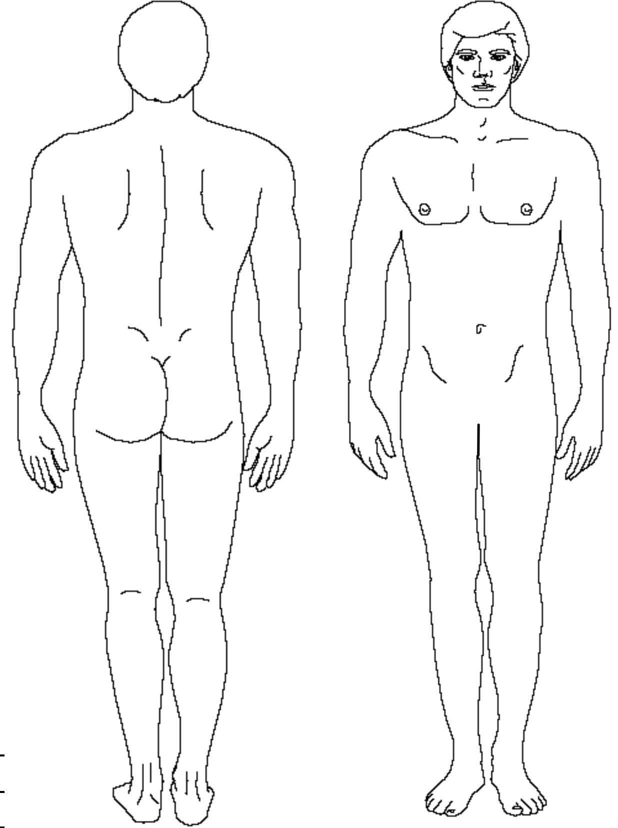
When did your symptoms begin? ______________________________

Are your symptoms getting worse? **No / Yes**
Does it keep you from working? **No / Yes**
Does it keep you from sleeping? **No / Yes**

Have you seen a chiropractor before? **No / Yes**

Are you currently under the care of a physician? **No / Yes**
Name of primary care physician: ______________________________

Indicate the location of your symptoms:



☐ **Current medications:** **Reason for taking them:**

☐ **Prior Illness / Injuries:**	**Yes**	**No**	**If yes, briefly explain.**
- Strains or sprains	☐	☐	____________
- Broken bone(s)	☐	☐	____________
- Fallen / struck unconscious	☐	☐	____________
- Auto accident / work injury	☐	☐	____________
☐ **Hospitalization / Surgeries**	☐	☐	____________
☐ **Major health conditions**	☐	☐	____________

☐ **Present Lifestyle Habits:**	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐

Do you have any reason to believe that you are currently pregnant?

No / Yes

Signature (Patient or Guardian) **Date**

JSB ☑: Indicates reviewed by the doctor with the patient at the time of the exam

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Review of Systems

Patient's Name ______________________________ DOB ____________ Date ____________

Please indicate all CURRENT or PAST conditions.
All information will be kept strictly confidential.

C = Current problem **P** = Past problem

☐ **C P Head / Spinal Pain**
- ☐ ☐ Headache
- ☐ ☐ Eye
- ☐ ☐ Ear
- ☐ ☐ Neck pain, stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Abdomen
- ☐ ☐ Chest
- ☐ ☐ Low back pain
- ☐ ☐ Sciatica
- ☐ ☐ Painful tailbone
- ☐ ☐ Poor posture
- ☐ ☐ Spinal curvature
- ☐ ☐ Foot trouble
- ☐ ☐ Swollen joints
- ☐ ☐ Bursitis

☐ **C P Numbness**
- ☐ ☐ Shoulders
- ☐ ☐ Upper Arm
- ☐ ☐ Forearm
- ☐ ☐ Hand
- ☐ ☐ Thigh
- ☐ ☐ Shin / calf
- ☐ ☐ Feet

☐ **C P Extremity Pain**
- ☐ ☐ Shoulders
- ☐ ☐ Upper Arm
- ☐ ☐ Elbows
- ☐ ☐ Forearm
- ☐ ☐ Hand
- ☐ ☐ Hips
- ☐ ☐ Thigh
- ☐ ☐ Knee
- ☐ ☐ Shin
- ☐ ☐ Ankle
- ☐ ☐ Feet

☐ **C P Cardiovascular**
- ☐ ☐ Hardening of arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heartbeat
- ☐ ☐ Slow heartbeat
- ☐ ☐ Swelling of ankles

☐ **C P Respiratory**
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spit up blood

☐ **C P Constitutional**
- ☐ ☐ Dizziness
- ☐ ☐ Fainting
- ☐ ☐ Concussion

☐ **C P Skin**
- ☐ ☐ Allergy
- ☐ ☐ Skin rash
- ☐ ☐ Enlarged glands

☐ **C P Gastrointestinal**
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Jaundice
- ☐ ☐ Liver trouble
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

☐ **C P Genitourinary**
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Loss of bladder control
- ☐ ☐ Kidney infection
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble

☐ **Family history of serious illness:** ______________________________

____

____

____

Signature (Patient or Guardian) **Date**

JSB ☑: Indicates reviewed by the doctor with the patient at the time of the exam

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REGISTRATION INFORMATION

Name ____ Today's Date ____________
Last First MI

Address ____
(Complete Mailing) Street Apt# City State Zip

Date of Birth: _____ / _____ / ________

Primary Phone* (______) _______ - _________ ☐ home ☐ cell ☐ work

Secondary Phone* (______) _______ - _________ ☐ home ☐ cell ☐ work

Employer_________________________ Occupation____

Emergency Contact___________________ Relationship_____________ Phone (______) _______ - ________

E-mail: _________________________ ☐ YES: You may contact me by e-mail, but I can opt out anytime.

☐ NO: Please, don't contact me by e-mail

Please choose one:

- ☐ I will pay my balance in full at time of service
- ☐ I prefer to make payment arrangements prior to services being rendered
- ☐ I intend to bill insurance:

Ins Company [ ] Representative [ ]

Ins Phone # [ ]

Group # [ ] Policy ID # [ ]

Payment Policy

By signing below, I understand that full payment for all services and products I receive from Solutions Chiropractic LLC is required at the time of service, except that portion billed to my insurance company. I understand that Solutions Chiropractic LLC may bill my insurance carrier directly, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance, or deductible required by my insurance. I instruct my insurance carrier to pay this office directly for all services and authorize the release of any information necessary to secure payment.

By signing this application I affirm that I have given true and complete information.

[ ] [ ]

Signature (Patient or Guardian) **Date**

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CONSENT: TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, the undersigned, consent to the use and disclosure of my Protected Health Information by Solutions Chiropractic LLC for the purpose of providing treatment to me, obtaining payment of services rendered to me, and for general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, collected or received by Solutions Chiropractic LLC, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of Solutions Chiropractic LLC, but that Solutions Chiropractic LLC is not required to agree to these restrictions. However, if Solutions Chiropractic LLC agrees to a restriction that I request, the restriction is binding on Solutions Chiropractic LLC.

I have been given the opportunity to review Solutions Chiropractic LLC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. This document is posted in plain view on the front desk near the intake window. Please notify our front desk if you wish to have a copy of our Notice of Privacy practices.

I have the right to revoke this consent, in writing, at any time, except to the extent that James Bowman DC or Solutions Chiropractic LLC has acted in reliance on this consent.

Print (Patient Name)

Signature (Patient or Guardian)

Date

PLEASE READ & INITIAL EACH ITEM BELOW

(1) I hereby authorize Solutions Chiropractic LLC to provide Chiropractic services for me.

(2) I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Solutions Chiropractic LLC.

(3) If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

(4) I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Solutions Chiropractic LLC

(5) I authorize release of patient's records to third parties requiring these records for determination of financial liability.

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INFORMED CONSENT: DIAGNOSIS & TREATMENT

Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. ***Any procedure intended to help may have complications.*** While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

I, the undersigned, hereby request and consent to the performance of chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) on me (or the patient named above, for whom I am legally responsible) by Dr. James Bowman, and/or his relief doctor who now or in the future treats me in the office.

I understand and am informed that in the practice of chiropractic there are some rare risks to treatment, including but not limited to soreness, inflammation, soft tissue injury, fractures, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above consent regarding treatment side-effects. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature (Patient or Guardian) **Date**

Signature (Dr. Jim Bowman DC) **Date**

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

Print (Patient Name) **Date of Birth**

for any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment. This authorization will be effective for one year.

Signature (Parent or Guardian) **Witnessed by**

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Business Agreement

(1) I understand that all responsibility for chiropractic services provided in this office for myself or my dependents is entirely mine, due and payable at the time services are rendered unless other arrangements have been made with Solutions Chiropractic LLC.

  a. In the event that payments are not paid in full within 30 days of the treatment date, I understand that a 1.5% service charge (i.e. 18% per annum) shall be added to my account.

  b. I further understand that any dishonored checks will be assessed a statutory handling and collection fee of $25.00 and any related bank fee incurred.

(2) I have signed and understand the authorized consent form given by Solutions Chiropractic for the modalities used within the office.

(3) I acknowledge that no guarantee, warranty or assurance has been given by anyone as to the treatment results that may be obtained.

(4) I grant my permission to Solutions Chiropractic LLC agents to telephone me at my home or at my workplace to discuss matters related to this consent, appointments, my treatment, or my account.

(5) I hereby authorize Solutions Chiropractic LLC to release any information necessary to process my family's medical claims.

(6) I acknowledge that I will give at least **24 hours notice** for cancellation of appointments and that I will be charged a late fee for all broken appointments, no shows and short notice cancellations. I understand that if I break an appointment for a third time that I will not be rescheduled and will be provided with medical care for 30 days only, to allow time to find another health care practitioner.

(7) The Fee Schedule maintained by Solutions Chiropractic LLC is based upon the full amount of code fees (associated with services provided and type of office visit) that are considered "usual and customary" for practitioners in the local area. Any party that pays in full on the day services are rendered qualifies to receive the "Time of Service" discount. All prices are subject to change and available upon request.

Signature (Patient or Guardian)

Date