

Neighborhood Chiropractic and Acupuncture LLC Registration and History

PATIENT INFORMATION

Last Name:	Date:
First Name	Middle Initial:
Address:	
City:	State: Zip:
Cell Phone Number:	Home Phone Number:
Email:	May we send you e-mail correspondence? <input type="radio"/> Yes <input type="radio"/> No
Sex: <input type="radio"/> M <input type="radio"/> F	Pronoun Preference: <input type="radio"/> He <input type="radio"/> She <input type="radio"/> They <input type="radio"/> Ze <input type="radio"/>
<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Domestic Partnership <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Minor	
Birthdate:	Age:
Occupation:	
Patient Employer and/or School:	
Work Phone Number:	May we call you at work? <input type="radio"/> Yes <input type="radio"/> No
Who is responsible for this account? <input type="radio"/> Self <input type="radio"/> Insurance Company <input type="radio"/> Guardian Name:	
Who do we thank for referring you?	

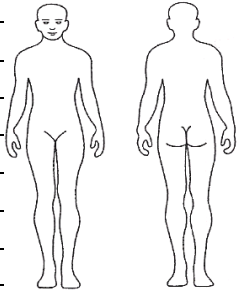
In Case of Emergency, Contact

Name:	Relationship:
Home Phone:	Work Phone:
Primary Care Physician:	Phone Number:

ACCIDENT INFORMATION

Is this condition due to an accident? <input type="radio"/> Yes <input type="radio"/> No	Date of Accident:
Type of Accident: <input type="radio"/> Auto <input type="radio"/> Work <input type="radio"/> Home <input type="radio"/> Other:	
To whom have you made report of your accident? <input type="radio"/> Auto Insurance:	
<input type="radio"/> Employer <input type="radio"/> Worker Comp. <input type="radio"/> Other:	
Claim # (if applicable):	Attorney Name (if applicable):

PATIENT CONDITION

Reason for your visit	
When did your symptoms appear?	
Is this condition getting progressively worse? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know	
Mark an X on the picture where you have pain, numbness, or tingling.	
Areas of your body that need special attention? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Describe:	
Rate the severity of pain from 1 (least pain) to 10 (most pain):	
Type of pain: <input type="radio"/> Sharp <input type="radio"/> Dull <input type="radio"/> Throbbing <input type="radio"/> Numbness <input type="radio"/> Aching <input type="radio"/> Shooting <input type="radio"/> Burning	
<input type="radio"/> Tingling <input type="radio"/> Cramps <input type="radio"/> Stiffness <input type="radio"/> Swelling <input type="radio"/> Other (describe):	
Location of numbness or tingling:	
How often do you have these symptoms?	
Is it constant or does it come and go?	
Does it interfere with your: <input type="radio"/> Work <input type="radio"/> Sleep <input type="radio"/> Daily Routine <input type="radio"/> Recreation	
Activities that are painful: <input type="radio"/> Sitting <input type="radio"/> Standing <input type="radio"/> Walking <input type="radio"/> Bending <input type="radio"/> Lying Down <input type="radio"/> Lovemaking <input type="radio"/> Other	
Are you experiencing any other symptoms in your body?	

HEALTH HISTORY

What treatment have you already had for your condition? <input type="radio"/> Medications <input type="radio"/> Surgery <input type="radio"/> Physical Therapy <input type="radio"/> Chiropractic Services <input type="radio"/> None <input type="radio"/> Other:		
Name of other practitioners who have treated you for this condition:		
Have you ever had chiropractic care? <input type="radio"/> Yes <input type="radio"/> No	Massage? <input type="radio"/> Yes <input type="radio"/> No	Acupuncture? <input type="radio"/> Yes <input type="radio"/> No
Date of Last: Physical Exam:	X-ray (Area):	Lab Work:
Spinal Exam:	MRI, CT-Scan or Bone Scan:	

Place a mark in the box to indicate if you have had any of the following:			
<input type="radio"/> AIDS/HIV	<input type="radio"/> Eating Disorder	<input type="radio"/> Kidney Disease	<input type="radio"/> Rheumatoid Arthritis
<input type="radio"/> Allergies to oils/ fragrance	<input type="radio"/> Easy Bruising	<input type="radio"/> Leg/Foot Disease	<input type="radio"/> Rheumatic Fever
<input type="radio"/> Anemia	<input type="radio"/> Emphysema	<input type="radio"/> Liver Disease	<input type="radio"/> Sciatica
<input type="radio"/> Arm/ Hand Pain	<input type="radio"/> Epilepsy/ seizures	<input type="radio"/> Low Back Problems	<input type="radio"/> Shoulder Problems
<input type="radio"/> Arthritis	<input type="radio"/> Fainting	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Skin Disease
<input type="radio"/> Asthma	<input type="radio"/> Fibroids	<input type="radio"/> Multiple Sclerosis	<input type="radio"/> Stroke
<input type="radio"/> Bleeding Disorders	<input type="radio"/> Fibromyalgia	<input type="radio"/> Neck Pain/ Stiffness	<input type="radio"/> Thyroid Problems
<input type="radio"/> Blood clots	<input type="radio"/> Glaucoma	<input type="radio"/> Open cuts or sore	<input type="radio"/> Transient Ischemic Attack (TIA)
<input type="radio"/> Cancer	<input type="radio"/> Gonorrhea	<input type="radio"/> Osteoporosis	<input type="radio"/> Tuberculosis
<input type="radio"/> Cataracts	<input type="radio"/> Headaches	<input type="radio"/> Pacemaker	<input type="radio"/> Tumors/ Growths
<input type="radio"/> Chemical Dependency	<input type="radio"/> Hearing Difficulty	<input type="radio"/> Parkinson's disease	<input type="radio"/> Typhoid
<input type="radio"/> Chicken Pox	<input type="radio"/> Heart Disease	<input type="radio"/> Pinched Nerve	<input type="radio"/> Ulcers
<input type="radio"/> Communicable disease	<input type="radio"/> Hepatitis	<input type="radio"/> Pneumonia	<input type="radio"/> Varicose Veins
<input type="radio"/> Contacts	<input type="radio"/> Herniated Disc	<input type="radio"/> Polio	<input type="radio"/> Venereal Disease
<input type="radio"/> Diabetes	<input type="radio"/> Hernia	<input type="radio"/> Prosthesis	
<input type="radio"/> Dizziness	<input type="radio"/> High Cholesterol	<input type="radio"/> Psychiatric Care	
	<input type="radio"/> Jaw Problems	<input type="radio"/> Respiratory Problems	
<input type="checkbox"/> Other condition not listed above:			

Exercise: <input type="radio"/> None <input type="radio"/> Moderate <input type="radio"/> Daily <input type="radio"/> Heavy Describe:
Work Activity: <input type="radio"/> Sitting <input type="radio"/> Standing <input type="radio"/> Light Labor <input type="radio"/> Heavy Labor
Habits: <input type="radio"/> Smoking: # Cigarettes or Packs/day? ____ How many years? ____ Were you ever a smoker? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Alcohol: # Drinks/week? ____ <input type="radio"/> Caffeine Drinks # Cups/Day? ____ <input type="radio"/> High Stress Level Reason:
Women: Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No Due Date: _____ Number of children: _____

Injuries/ Surgeries (Include a date and a description):

Falls:
Head Injuries:
Broken Bones:
Dislocations:
Surgeries:
Car Accidents:

Family Health History

Has anyone in your immediate family had the following conditions? (including grandparents): <input type="radio"/> Heart Disease <input type="radio"/> Stroke <input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Other Describe any selected: <input type="radio"/> Other Family Diseases:
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Medications: _____ For what condition?
Vitamins/Herbs/Supplements:
Allergies:
Is there anything else you would like to share with your doctor?

To the best of my knowledge, this information is complete and correct. I understand it is my responsibility to inform my doctor/Clinic if there are any changes to my health or personal information.

Signature _____	Printed Name _____	Date _____
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Neighborhood Chiropractic and Acupuncture LLC
Workman's Comp Accident Intake

Last Name:		Date:
First Name:		Middle Initial:
Age:	Occupation:	Date of Accident:
Claim #:	Insurance Co:	Time of Accident: <input type="radio"/> am <input type="radio"/> pm

Please describe the accident in your own words:

AT THE SCENE

Did medical personal (ambulance, fire) come to the scene? no yes

If yes, were you treated at the scene? no yes, please explain:

HOSPITAL / EMERGENCY DEPARTMENT

Did you go to the Emergency Room? no yes

If yes, what was the name of the Hospital?

What was your doctor's name (if known)?

Did you go by: ambulance someone drove me I drove myself

When did you go the emergency room? Immediately after the accident The next day
 Two or more days later ()# hours after the accident

Were x-rays taken? no yes I had x-rays, but I am not sure what was x-rayed.

If yes, what x-rays were taken? neck upper back mid back low back

LEFT: shoulder upper arm elbow forearm wrist hand fingers
 hip thigh knee calf ankle foot toes

RIGHT: shoulder upper arm elbow forearm wrist hand fingers
 hip thigh knee calf ankle foot toes

Additional x-rays not marked above:

Do you know the results your x-rays? no yes, please explain:

Were any additional tests performed? no yes unsure

If yes, do you know what tests were performed? no yes

If yes, check all that apply: blood CAT/CT scan MRI Other:

Do you know the results of any of these tests? no yes, please explain

Did you receive a diagnosis? no yes, please explain:

Please explain treatment given in the emergency room:

Upon leaving, what treatment plan were you given?

What prescriptions (and dosing) were you given?

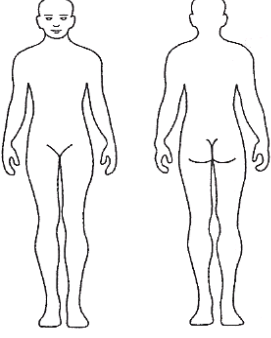
Neighborhood Chiropractic and Acupuncture LLC
Workman's Comp Accident Intake

AFTER THE ACCIDENT

Have you seen any other doctor since the accident? <input type="radio"/> no <input type="radio"/> yes			
If yes, what was the name of the physician?			
Was this doctor your primary care physician? <input type="radio"/> no <input type="radio"/> yes			
What date(s) did you see this doctor?			
If yes, what x-rays were taken? <input type="radio"/> neck <input type="radio"/> upper back <input type="radio"/> mid back <input type="radio"/> low back			
LEFT:	<input type="radio"/> shoulder	<input type="radio"/> upper arm	<input type="radio"/> elbow <input type="radio"/> forearm <input type="radio"/> wrist <input type="radio"/> hand <input type="radio"/> fingers
	<input type="radio"/> hip	<input type="radio"/> thigh	<input type="radio"/> knee <input type="radio"/> calf <input type="radio"/> ankle <input type="radio"/> foot <input type="radio"/> toes
RIGHT:	<input type="radio"/> shoulder	<input type="radio"/> upper arm	<input type="radio"/> elbow <input type="radio"/> forearm <input type="radio"/> wrist <input type="radio"/> hand <input type="radio"/> fingers
	<input type="radio"/> hip	<input type="radio"/> thigh	<input type="radio"/> knee <input type="radio"/> calf <input type="radio"/> ankle <input type="radio"/> foot <input type="radio"/> toes
<input type="radio"/> Additional x-rays not marked above:			
Do you know the results your x-rays? <input type="radio"/> no <input type="radio"/> yes, please explain:			
Were any additional tests performed? <input type="radio"/> no <input type="radio"/> yes <input type="radio"/> unsure			
If yes, do you know what tests were performed? <input type="radio"/> no <input type="radio"/> yes			
If yes, please check all that apply: <input type="radio"/> blood <input type="radio"/> CAT/CT scan <input type="radio"/> MRI <input type="radio"/> Other:			
Do you know the results of any of these tests? <input type="radio"/> no <input type="radio"/> yes, please explain			
Did you receive a diagnosis? <input type="radio"/> no <input type="radio"/> yes, please explain:			
Please explain treatment given in the doctor's office:			
Upon leaving, what treatment plan were you given?			
What prescriptions (and dosing) were you given?			
Have you been able to work since the injury? <input type="radio"/> yes <input type="radio"/> no, how many days have you missed?			
Prior to the injury, were you able to work on an equal basis with others your age? <input type="radio"/> yes <input type="radio"/> no			
If no, what has changed?			
Have you had any of the following symptoms since your injury? (Check all that apply.)			
<input type="radio"/> arm / shoulder pain	<input type="radio"/> ear ringing	<input type="radio"/> irritability	<input type="radio"/> neck stiffness
<input type="radio"/> back pain	<input type="radio"/> fatigue	<input type="radio"/> jaw problems	<input type="radio"/> shortness of breath
<input type="radio"/> back stiffness	<input type="radio"/> feet / toe numbness	<input type="radio"/> leg pain	<input type="radio"/> sleep difficulty
<input type="radio"/> chest pain	<input type="radio"/> hand / finger numbness	<input type="radio"/> memory loss	<input type="radio"/> stomach upset
<input type="radio"/> dizziness	<input type="radio"/> or stiffness	<input type="radio"/> nausea	<input type="radio"/> tension
<input type="radio"/> ear buzzing	<input type="radio"/> headaches	<input type="radio"/> neck pain	<input type="radio"/> vision blurred
Is the condition getting progressively worse? <input type="radio"/> no <input type="radio"/> yes <input type="radio"/> unsure			
Movements that are painful: <input type="radio"/> sitting <input type="radio"/> standing <input type="radio"/> walking <input type="radio"/> bending <input type="radio"/> lying down			
Rate the severity of your pain from 1 (least pain) to 10 (severe pain):			
Type of pain (check all that apply): <input type="radio"/> sharp <input type="radio"/> dull <input type="radio"/> throbbing <input type="radio"/> numbness <input type="radio"/> aching <input type="radio"/> shooting			
<input type="radio"/> burning <input type="radio"/> tingling <input type="radio"/> cramps <input type="radio"/> stiffness <input type="radio"/> swelling <input type="radio"/> other:			
How often do you get this pain?		Is the pain: <input type="radio"/> constant <input type="radio"/> come and go	
Does it interfere with your: <input type="radio"/> work <input type="radio"/> sleep <input type="radio"/> daily routine <input type="radio"/> recreation			

Neighborhood Chiropractic and Acupuncture LLC
Workman's Comp Accident Intake

Place an X on the picture here you have continued pain, numbness, tingling.



Is there anything else you would like us to know?

Have you received any additional treatment other than what is listed above? <input type="radio"/> no <input type="radio"/> yes If yes, please fill in the information. Use the bottom and back side of this form if more space is needed.			
Dates	Name of Practitioner	Type of Practitioner	Treatment
		<input type="radio"/> MD <input type="radio"/> ND <input type="radio"/> LAc <input type="radio"/> LMT <input type="radio"/> PT <input type="radio"/> DC <input type="radio"/> DO <input type="radio"/> other:	
		<input type="radio"/> MD <input type="radio"/> ND <input type="radio"/> LAc <input type="radio"/> LMT <input type="radio"/> PT <input type="radio"/> DC <input type="radio"/> DO <input type="radio"/> other:	

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I or my minor child have any changes to my health.

Signature of patient (or parent/ guardian or personal representative of patient) Date

Relationship to patient: self parent guardian representative

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Form B1100

rev 3/27/2003

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

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓔ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓔ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓔ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓔ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓔ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓔ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓔ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓔ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

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

Back
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Score

Neck Index

Form N1-100

rev 3/27/2003

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



6040 SE Belmont Street Suite 1230 Portland, Oregon 97215
(P) 503.236.8701 (F) 503.236.8710

HIPAA Policy – Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practice of Neighborhood Chiropractic and Acupuncture which describes the Practice policies and procedures regarding the use and disclosure of any of my Protected Health information created, received, or maintain by the Practice.

Missed/Cancellation Policy

When you make an appointment, you're paying for the practitioner's time. Appointments require a 24-hour business day cancellation notice. For Saturday, Sunday, and Monday appointments, cancellation must occur prior to Friday at noon. **If we do not receive 24-hour business day notice, you will be charged a \$25 appointment cancellation fee.** We are unable to bill insurance companies for missed appointments. Thank you for your understanding of this matter.

Communication Consent

We are adding different communication options to provide you with more personalized and integrative ways to inform you about your care. In order to communicate information regarding your care, account, appointments, and the clinic, we need permission to do so. We will never sell any of your information, nor use it for unsolicited marketing purposes.

By signing this, you authorize Neighborhood Chiropractic and/or our automated third-party reminder service to contact you and/or named authorized person(s) and to convey Personal Health Information by the following methods and assume responsibility to notify Neighborhood Chiropractic whenever this information changes.

Text Message: Yes Text: _____
 No, provider may not contact me by text message.

Detailed Voicemail: Yes Phone: _____
 No, Provider may only leave a name and phone number.

Detailed Email: Yes Email: _____
 No, provider may not contact me by email.

Please list names & relationships of other people authorized to receive information about your care:

I hereby attest the above information is correct, and that I have read and understood the above policies.

Print Name: _____ Date: _____

Signature: _____