

**BEFORE THE  
BOARD OF CHIROPRACTIC EXAMINERS  
STATE OF OREGON**

In the Matter of

Todd Hansen DC

License No. 3045

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STIPULATED FINAL ORDER

Case # 2009-3024, 2010-1019, 2011-1028,  
2011-1046, 2011-1048, 2012-1001,  
2012-1003, 2012-1004, 2012-1005,  
2012-1006, 2012-1007, 2012-1011, 2012-  
1022, 2012-1033, 2012-2000, 2012-3001

The Board of Chiropractic Examiners (Board) is the state agency responsible for licensing, regulating and disciplining chiropractic physicians in the State of Oregon. Todd Hansen DC (Licensee) is licensed by the Board to practice as a chiropractic physician in the State of Oregon.

Findings of Fact

1.

On October 26, 2011, the Board issued an Amended Notice of Proposed Disciplinary Action for Revocation against Licensee. In the notice, there were several allegations of violations in regards to violations of the Board's previous order; several allegations that Licensee caused physical injury to patients during treatment, and unprofessional conduct in relations to inappropriate sexual contact or remarks to patients he provided treatment to. The Board hereby incorporates by reference paragraphs 1 through 5 of the Amended Notice issued on that date and asserts that those are the findings they rely on in the issuance of this final order.

Conclusions of Law

2.

The Board finds that Licensee committed the following violations of conduct described in the Amended Notice of Discipline as to paragraph 1, this violates ORS 684.100 (1)(f) and (p); OAR 811-035-0015(3), (10) and (23) and 811-010-0110(5) and (6). For conduct alleged in paragraph 2 this violates ORS 684.100(f)(A) and (C), (q), OAR 811-035-0015(6). For conduct alleged in paragraph 3, this violates ORS 684.100(1)(f)(A) and OAR 811-035-0015(1)(a) through (e). For conduct alleged in paragraph 4, this violates ORS 684.100(f)(A), and OAR 811-035-0015(9) and (13). For conduct alleged in paragraph 5 this violates ORS 684.100(f)(A) and OAR 811-015-0005(1) and (3).

## Stipulations

3.

Therefore, pursuant to ORS 183.415(5) and ORS 684.100(9)(e) the OBCE orders:

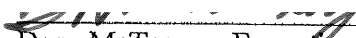
1. The parties have agreed to enter this stipulated final order. Licensee agrees that he is aware of his right to a hearing with his attorney present to contest the charges and hereby waives that right and agrees to entry of this order. Licensee agrees to waive any right to appeal. In lieu of proceeding to the contested case hearing scheduled for October 3, 2012, the parties wish to settle and resolve the above matter without further proceedings.
2. Licensee agrees to immediately surrender his license to practice chiropractic in the State of Oregon. Licensee agrees not to renew or reapply for Oregon licensure for a period of four years after this order becomes final.
3. Licensee agrees if he ever should reapply for licensure with the Board, that the Board has discretion pursuant to ORS 684.100(9), 684.040(2)(a) and 670.280, to require additional conditions be met by Licensee prior to licensure, which may include license limitations. The Board will review the application based on the facts of this case and any new information the Board has in their possession which bear a relationship to Licensee's qualifications for licensure at that time.
4. If Licensee violates any of the terms of this order, it may result in further discipline pursuant to ORS 684.100.
5. Signature of this agreement in no way guarantees that the Board agrees to relicense Licensee at any time in the future, or in any way would limit the Board from placing conditions on a future license.
6. The Board agrees to waive assessment of costs for the disciplinary proceeding against Licensee in this case.

7. This order is effective on the date signed by the Board and is a public record.

IT IS SO ORDERED this 6 day of September, 2012.

**BOARD OF CHIROPRACTIC EXAMINERS**  
State of Oregon

Original Signatures are on file at OBCE office

By:   
Dave McTeague, Executive Director

9/12/2012

Original Signatures are on file at OBCE office

By:   
Todd Hansen, D.C.

Dated: 9/6/2012

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**BEFORE THE  
BOARD OF CHIROPRACTIC EXAMINERS  
STATE OF OREGON**

6 In the Matter of ) AMENDED  
7 ) NOTICE OF PROPOSED  
8 Todd Hansen DC ) DISCIPLINARY ACTION  
9 )  
10 License No. 3045 )  
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12 ) Case # 2010-1019, 2011-1028  
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15 The Board of Chiropractic Examiners (Board) is the state agency responsible for  
16 licensing, regulating and disciplining chiropractic physicians in the State of Oregon. Todd  
17 Hansen DC (Licensee) is licensed by the Board to practice as a chiropractic physician in the State  
18 of Oregon. The Board proposes to discipline Licensee for the following reasons.  
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- 20 1.
- 21 A. On January 25, 2010, the Board served a Proposed Notice of Discipline on  
22 Licensee for his failure to properly train or supervise various Chiropractic  
23 Assistants who worked in his clinic during November and December 2009. On  
24 July 21, 2010, Licensee signed a Stipulated Final Order with the Board which  
25 required that Licensee must abide by the laws regarding Chiropractic Assistant  
26 supervision and all requirements of OAR 811-035-0015. The Order also required  
27 that he had a permanent restriction on his license that all assistants must be trained  
28 by an outside source or course and must be certified prior to beginning  
29 employment with him or his clinic. The Order also stated that failure to complete  
30 the terms of the order may result in further discipline. (Case Number 2009-3024)  
31
- 32 B. After the Stipulated Final Order was executed in July 2010, Licensee continued to  
33 leave the clinic while his Chiropractic Assistants provided care to patients. No  
34 other chiropractor was supervising the assistants. On September 20, 2010, Patient  
35 1 received ultrasound from a CA after Licensee left the clinic for the day. In  
36 September 2010, Patient 2 received e-stim from a CA when Licensee was at  
37 lunch.  
38
- 39 C. Patient 3 had cold laser therapy and had several early morning appointments with  
40 Licensee. When she would arrive at the office, Licensee was not yet there. The  
41 Chiropractic Assistant would often assist Patient 3 with her therapy prior to

1 Licensee's arrival, or often the patient would start the machine herself and would  
2 be billed for that therapy.

3  
4 D. Since signing the stipulated order in July 2010, Licensee was OFTEN late for  
5 work each morning, even if patients were scheduled. For patients that were  
6 scheduled at 8 a.m., Licensee would OFTEN come in at 8:15 a.m. or later. Often,  
7 a Chiropractic Assistant would begin the therapy work when the patient arrived,  
8 prior to Licensee's arrival. The Assistant would not be supervised by any  
9 chiropractic physician during that time.

10  
11 E. In August 2010, Licensee allowed Staff 1 to provide spinal screenings in a booth  
12 at the Douglas County Fair and Staff 1 staffed the booth alone without any direct  
13 supervision, while he was at the clinic.

14  
15 F. Licensee has violated his Stipulated Order entered into on July 21, 2010

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17 2.

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19 A. Patient 4 was treated by Licensee in 2005 for cervical adjustments and ceased  
20 going to him for treatment when he hurt her neck when doing a cervical  
21 adjustment.

22  
23 B. Patient 5 went to Licensee in 2008 for a severe back injury and said that Licensee  
24 was very forceful and rough in his treatment of him. He described it as Licensee  
25 "throwing me around." After he had received treatment, he was almost unable to  
26 walk and had to seek emergency care from his medical doctor the next day.  
27 Patient 5 was told by his medical doctor that his back had been damaged further  
28 by Licensee's care. Patient 5 never returned to Licensee for treatment.

29  
30 C. Patient 6 was seeking treatment in 2003 and was injured by a cervical treatment  
31 administered by Licensee. She still suffers from neck pain, migraines and muscle  
32 spasms.

33  
34 D. Patient 7, also a chiropractor, went to see Licensee for a neck adjustment in 2007.  
35 He said his neck was severely wrenched in a very aggressive treatment. The  
36 treatment hurt his jaw so much that he could not chew meat for several weeks.

37  
38 E. Staff 2 recalled how she watched as a patient had received a broken rib during a  
39 session of treatment from Licensee. Staff 2 also had her own neck adjustments  
40 from Licensee and had her neck severely wrenched so she stopped going to  
41 Licensee.  
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- F. Several staff had patients complain to them that their adjustments from Licensee had caused pain or injury. The forcefulness and aggressive nature of the adjustments made the staff fearful of him injuring patients.
- G. Patient 8 was treated by Licensee several times. At one point, Licensee hurt her neck so she stopped getting treatment. She complained that Licensee would rush her treatment, never warming up or loosening the cervical area before the adjustment.
- H. Patient 9 received treatments in 2008 that were very rough and Licensee ignored her when she told him that she had difficulty swallowing and her fingers were numb. Once, Licensee injured her collarbone during a treatment. This was confirmed by subsequent treating physicians who told her that the collarbone was frozen. Patient 9 still has neck and shoulder pain.
- I. Patient 10 sought treatment in 2009 and her pain would get worse with each treatment. She did not progress so she stopped going to Licensee.
- J. Patient 11 saw Licensee in early 2010 and had a treatment that made it hurt to breathe for a week. She could barely dress herself and could not wear a bra. She told Licensee on a subsequent visit that he had injured her and he did not apologize.
- K. Patient 12 said that her treatments were very rough and that sometimes she was sore for several days after receiving treatment from Licensee.
- L. Patient 13 even told Licensee to adjust her slowly and to let her muscles relax prior to doing the adjustment, but he wouldn't listen. For three years she said he was "way too rough." Patient 13 said she practically had to scream at him not to rush the treatment. On one occasion he wrenched her tense neck so severely that she thought she was going to pass out.
- M. Patient 14 said her treatments were very rough and that he would put all his weight into it.
- N. Patient 15 had neck adjustments while she was staff in 2009 and found the adjustments to be very forceful. She had migraines after the treatment; something she had never had prior.
- O. Patient 16 sought care from Licensee in September 2009 for a motor vehicle accident. During a treatment, Licensee caused so much pain while adjusting her that she cried out in pain indicating to Licensee that he had hurt her. During that

1 treatment Licensee also dug his knuckles into her spine area and Patient 16 again  
2 told him that it was hurting her physically when he did that.  
3

- 4 P. Patient 22 was an 84 year old woman who had a plate in her neck and was seen  
5 approximately 9 times from December 2010 through June 2011. Patient 22 told  
6 Licensee about her neck issues and when he adjusted her he would put his entire  
7 body weight down on her causing the breath to be taken out of her and hurt her  
8 chest. Patient 22 also had a pace maker in her chest and Licensee would use a  
9 large amount of force on her chest near the pace maker location. Patient 22 felt  
10 that the treatments which she received were very rough and in the last treatment  
11 on June 6, 2011, she believed that she was injured. During the treatment she said  
12 that she cried out in pain and could barely walk after the treatment she received.  
13

14  
15 3.

- 16 A. Patient 17 saw Licensee in 2006-2007 as a patient. On the first visit, Licensee  
17 made her uncomfortable by telling her he liked her shirt and complimenting how  
18 muscular she was. On the second visit, Licensee asked her a lot of personal, non-  
19 medical questions and started to come into her space, getting very close to her  
20 during treatment. He said to her "I'll bet you are really good at volleyball, maybe  
21 I could get private lessons from you." Patient 17 felt like Licensee was outwardly  
22 flirting with her. Licensee then showed up at one of Patient 17's volleyball  
23 matches. She had not invited him to do so. On one visit when Patient 17 had her  
24 14 year old son with her, Licensee asked her personal questions and stood very  
25 close to her. While she was standing at the front desk Licensee rubbed her  
26 shoulders and asked her what type of perfume she was wearing. Her son  
27 commented how inappropriate Licensee had been toward his mother to her.  
28 Patient 17 discontinued further treatment due to her discomfort with his behavior.  
29
- 30 B. Patient 9 saw Licensee in 2005-2006. Licensee was overly complimentary to her  
31 from the first visit, commenting on her muscular back and shoulders. He would  
32 even invite passing staff to look at her shoulders. During one treatment, Licensee  
33 slapped Patient 9 on the bottom while she was lying on her side. She sat up  
34 suddenly and told him never to do that again. Licensee was speechless but did not  
35 apologize.  
36
- 37 C. Patient 18 saw Licensee in 2009. After 6 visits or so, Licensee began to stand too  
38 close to her, was very flirtatious and always over complimented her on her  
39 appearance. He told her she was "so pretty," continually commenting on her hair  
40 and clothes. Licensee would be providing treatment to her and would leave his  
41 hand on her thigh while he continued to talk to her. He would also let his hand  
42 linger on her neck after adjusting her. Patient 18 also noticed that Licensee would  
43 drape his body over hers while performing treatments, which was not something

1 she experienced with other physicians' chiropractic treatments. She was so  
2 concerned she sought advice from other health professionals who advised her to  
3 stop seeing Licensee.  
4

5 D. Patient 19 was a patient in 2002. During a treatment Licensee slapped her on the  
6 bottom and Patient 19 was so upset, she stopped going to him because of this.  
7

8 E. Patient 20 saw him in approximately 2005. Licensee always commented on her  
9 appearance, saying she was very muscular. This made Patient 20 very  
10 uncomfortable.  
11

12 F. Patient 21 has seen Licensee as a patient since January 2010. Between April and  
13 July of 2010, Licensee and Patient 21 exchanged over 200 calls or texts between  
14 their cell phones. Licensee and Patient 21 also confided in each other almost daily  
15 and socialized with one another. Patient 21 admitted that she did not see anything  
16 wrong with a patient dating their doctor. In an interview, Licensee admitted to  
17 the Board that he had started a sexual relationship with this patient and during  
18 September 2010 he and Patient 21 were sexually intimate on at least two  
19 occasions. Licensee also admitted that he knew he was in violation of  
20 administrative rules regarding boundaries with patients, and further stated that he  
21 had not terminated the doctor-patient relationship with Patient 21 prior to the  
22 relationship with her.  
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25 G. Various staff have also been treated by Licensee as patients. Staff 3 was a patient  
26 first in 2004 and staff in 2005. Licensee solicited her for a sexual relationship  
27 while she was a patient and then a staff member. Staff 3 said they kissed and  
28 embraced in a treatment room. Licensee would spend extended time with her as a  
29 patient and would often rub her shoulders and the top of her chest area and below  
30 her beltline on her back. Licensee would often text her, trying to get her into a  
31 sexual relationship with him and wanted her to confide in him about the status of  
32 her marriage. Licensee was often inappropriate during treatments, commenting on  
33 her appearance, and telling her how sexy she looked. During one treatment, he  
34 cornered her in the x-ray room and shut the door, saying "what do you want to do?  
35 Too bad we are not alone." Licensee wrote her a note stating "I really want to be  
36 with you, I hope this happens soon." Licensee often asked her to administer  
37 therapy to him, such as ultrasound, and have her close the door. Licensee later  
38 fired Staff 3, telling her his wife made him do so. Licensee then asked Staff 3 to  
39 meet him at a park telling her it was about future employment, where he tried to  
40 convince her to go to a motel room with him. Licensee tried to hug and kiss her  
41 while talking in the car.  
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- 1 H. Staff 4 was first a patient for two months in 2008 and then became staff that same  
2 year. She was also his babysitter for his children. During treatment, Licensee  
3 asked her to lift up her shirt so he could see her muscular abdominals and back  
4 muscles. Over time, Licensee became more touchy and overly complimentary of  
5 her appearance. One time he commented “how good you look, I want to go for a  
6 ride in your car with you sometime.” Licensee texted Staff 4 about her tanned  
7 body, writing “Heels, abs, tanned, attractive, 21. Do you know anyone resembling  
8 these characteristic(s)?” Staff 4 never went back for treatment after this, and was  
9 extremely upset and disgusted. One treatment, Staff 4 came wearing a lace shirt  
10 and Licensee told her “that would look great with nothing underneath.”  
11
- 12 I. Patient 8 also worked for Licensee. Patient 8 says he often would compliment her  
13 on her body, her looks or clothing. Licensee lent her his car, and paid her \$500 to  
14 quit smoking. Licensee helped her pay for college tuition.  
15
- 16 J. Various staff witnessed the inappropriate compliments to patients, flirting  
17 behavior and several staff said that Licensee made comments to them about his  
18 patients that were of a sexual nature.  
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4.

- 22 A. Licensee has admitted engaging in the use of illicitly prescribed steroids and HGH  
23 (Human Growth Hormone) that he received in 2003-2007 from Palm Beach  
24 Rejuvenation Center (PBRC) in Florida. Licensee has failed to provide evidence that  
25 his 2003-2007 prescriptions for steroids and HGH were legal or valid. Additionally,  
26 Licensee initially provided false statements to the OBCE regarding his use of illicit  
27 substances.
- 28 B. Licensee divulged to witnesses how he had used steroids and HGH extensively during  
29 this time period. Staff members found drug wrappers in the trash of Licensee’s clinic in  
30 2005 and told another DC who was working there. Various small packages were sent to  
31 the clinic with the names David Smith or David Rodriguez as the addressee. The  
32 packages were from Germany and Mexico, Austria and Greece. Staff noted that  
33 Licensee always took possession of these packages, and explained to one that they  
34 contained steroids and HGH. Staff also found various syringes in Licensee’s desk  
35 drawer as well as containers thought to be HGH, several of them with pictures of  
36 animals on the container. Licensee would order staff to leave the packages from  
37 Germany and Greece on the refrigerator for a few days, to see if authorities were  
38 tracking the packages. Staff also noticed that Licensee was very moody and prone to  
39 angry outbursts. Licensee admitted to other staff that he participated in self injecting of  
40 steroids in the clinic. Licensee did not have a valid prescription for testosterone from a  
41 legitimate medical provider until 2008.  
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A. For Staff 1, 2, 3 and 4 who also received chiropractic treatment as patients, Licensee did not keep accurate and complete chart notes on the treatment they were provided. In investigation, Licensee admitted that he did not keep ongoing charts when he provided staff with chiropractic care.

6.

The Board finds that Licensee's conduct during investigation are violations as follows; for conduct described in paragraph 1, this violates ORS 684.100 (1)(f) and (p); OAR 811-035-0015(3), (10) and (23) and 811-010-0110(5) and (6). For conduct alleged in paragraph 2 this violates ORS 684.100(f)(A) and (C), (q), OAR 811-035-0015(6). For conduct alleged in paragraph 3, this violates ORS 684.100(1)(f)(A) and OAR 811-035-0015(1)(a) through (e). For conduct alleged in paragraph 4, this violates ORS 684.100(f)(A), and OAR 811-035-0015(9) and (13). For conduct alleged in paragraph 5 this violates ORS 684.100(f)(A) and OAR 811-015-0005(1) and (3).

7.

Due to the aforementioned violations, the OBCE proposes to revoke Licensee's license.

8.

Licensee shall pay costs of this disciplinary proceeding, including investigative costs and attorney fees pursuant to ORS 684.100(9)(g).

9.

Licensee has the right, if Licensee requests, to have a formal contested case hearing before the Office of Administrative Hearings to contest the matter set out above. At the hearing, Licensee may be represented by an attorney and subpoena and cross examine witnesses. That request for hearing must be made in writing to the OBCE, must be received by the OBCE within 30 days from the mailing of this notice (or if not mailed, the date of personal service), and must be accompanied by a written answer to the charges contained in this notice.

10.

The answer shall be made in writing to the OBCE and shall include an admission or denial of each factual matter alleged in this notice, and a short plain statement of each relevant affirmative defense Licensee may have. Except for good cause, factual matters alleged in this notice and not denied in the answer will be considered a waiver of such defense; new matters alleged in this answer (affirmative defenses) shall be presumed to be denied by the agency and evidence shall not be taken on any issue not raised in the notice and answer.

1 If Licensee requests a hearing, before commencement of that hearing, Licensee will be  
2 given information on the procedures, rights of representation and other rights of the parties  
3 relating to the conduct of the hearing as required under ORS 183.413-415.  
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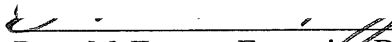
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6 12.

7 If Licensee fails to request a hearing within 30 days, or fails to appear as scheduled at the  
8 hearing, the OBCE may issue a final order by default and impose the above sanctions against  
9 Licensee. Upon default order of the Board or failure to appear, the contents of the Board's file  
10 regarding the subject of this automatically become part of the evidentiary record of this  
11 disciplinary action upon default for the purpose of proving a prima facie case.  
12

13  
14 DATED October 26, 2011.

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16 BOARD OF CHIROPRACTIC EXAMINERS  
17 State of Oregon

18 *Original signatures on file at OBCE office*

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20 By:   
21 Dave McTeague, Executive Director  
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County of Marion ) Case # 2010-1019, 2011-1028

I, Dave McTeague, being first duly sworn, state that I am the Executive Director of the Board of Chiropractic Examiners of the State of Oregon, and as such, am authorized to verify pleadings in this case: and that the foregoing Notice is true to the best of my knowledge as I verily believe.

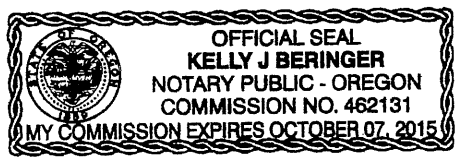
*Original signatures on file at OBCE office*

DAVE McTEAGUE, EXECUTIVE DIRECTOR  
OREGON BOARD OF CHIROPRACTIC EXAMINERS

SUBSCRIBED AND SWORN to before me  
this 25<sup>th</sup> day of October, 2011.

*Original signatures on file at OBCE office*

NOTARY PUBLIC FOR OREGON  
My Commission Expires: 10/7/2015



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**Certificate of Service**

I, Dave McTeague, certify that on October 26, 2011, I served the foregoing Amended Notice of Proposed Disciplinary Action upon the party hereto by mailing, certified mail, postage prepaid, a true, exact and full copy thereof to:

Todd Hansen, DC  
Pacific Crest Chiropractic & Wellness Center  
2270 NW Troost St.  
Roseburg, OR 97471

By regular mail to:

Charles E. Bolen, Attorney at Law  
Hornecker, Cowling, Hassen & Heysell, L.L.P.  
717 Murphy Road  
Medford, Oregon 97504

*Original signatures on file at OBCE office*

\_\_\_\_\_  
Dave McTeague  
Executive Director  
Oregon Board of Chiropractic Examiners