MARCUM CHIROPRACTIC/4310 N. Interstate Ave. Portland OR 97217/503-235-7130

REGISTRATION FORM

(Please Print)

Today's date:	Who referred you here?

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

City:	State:	ZIP Code:	Cell phone no.: ( )

Occupation:	Employer:	Employer phone no.: ( )

Email:

I prefer to receive specials offers and coupons by email ❑ post ❑

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary car insurance:					

Auto Claim #	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **MARCUM CHIROPRACTIC** or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Marcum Chiropractic Clinic
4310 N. Interstate Ave. Portland OR 97217 / 503-235-7130

Patient Consent Form

Patient Name: _____ **Date of Birth:** _____

___ I hereby authorize Marcum Chiropractic Clinic to release medical information regarding my current condition to my insurance company for purposes of payment and/or quality reviews; and to referring, consulting/treating physicians, or other medical providers as necessary to support continuation of care.

___ I authorize payment of insurance benefits to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. **I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.** I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be due immediately.

___ I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that if I want a more detailed account of how my Patient Health Information is going to be used in this office and my rights concerning those records, I can request and obtain a copy of the **HIPAA NOTICE** that is available at the front desk. I will inform the office if there is anyone that I do not want to receive my medical records.

___ I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens I may apply ice to the area (15 min. max.) and rest. If I am concerned about the discomfort or develop any new symptoms I can call **(503) 235-7130** to speak with the doctor. If I am unable to contact the doctor, I can present myself to an emergency department for evaluation/care.

___ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic named below.

___ I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the purpose of chiropractic adjustments and other procedures. I understand that, like in all forms of medicine, results are not guaranteed.

___ I further understand and am informed that as in all healthcare, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains, sprains, disc injuries and strokes. I expect the doctor to exercise judgment during the course of the procedure which the doctor believes at the time, based upon the facts then known, is in my best interests.

___ I have read the above consent with the doctor as indicated by my initials. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment.

I have read this form and understand its contents on this date. **Please initial each paragraph and sign.**

_____ _____ _____

Signature of Patient (or Guardian) **Date** **Todd J. Hartwig, M.S., D.C.**

MARCUM CHIROPRACTIC CLINIC

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HEALTH QUESTIONNAIRE

Note: PLEASE ANSWER EVERY QUESTION

If something does not apply to you put "NA". If you need help filling out this form please ask the receptionist.

Patient Name: _____ Date of Birth: _____

Date and Time of injury: _____

Chief complaints (describe symptoms, include location): _____

_____

_____

Is it ☐ constant ☐ comes & goes _____

Does it interfere with: ☐ work ☐ sleep ☐ daily routine ☐ recreation

☐ Headache	☐ Loss of memory	☐ Cold feet
☐ Neck pain/stiffness	☐ Fatigue	☐ Head feels too heavy
☐ Mid back pain	☐ Tension	☐ Diarrhea
☐ Low back pain	☐ Shortness of breath	☐ Constipation
☐ Pain in arms	☐ Irritability	☐ Stomach upset/pain
☐ Pain in legs	☐ Depression	☐ Blood in urine
☐ Eyes sensitive to light	☐ Difficulty concentrating	☐ Difficulty controlling urine stream
☐ Dizziness	☐ Sleep problems	☐ Chest pain
☐ Fainting	☐ Numbness in toes	☐ Nervousness/anxiety
☐ Ringing/buzzing in ears	☐ Numbness in fingers	☐ Cold sweats
☐ Nausea	☐ Pins & needles in arms	☐ Other:
☐ Loss of balance	☐ Pins & needles in legs	☐ Other:
☐ Loss of smell/taste	☐ Cold hands	☐ Other:

Are there any other areas of complaint? _____

_____

_____

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes

When and for what? _____

_____

Date of last: Physical exam _____ Spinal exam _____

Breast exam/mammogram (women) _____ Prostate exam (men) _____

(Women only) Are you pregnant? ☐ No ☐ Yes

List all medication you are currently taking

MEDICATION	VITAMINS/HERBS/MINERALS
☐	☐
☐	☐
☐	☐
☐	☐

_____ _____

Patient Signature Date

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4310 N. INTERSTATE AVE. PORTLAND OR 97217 / 503-235-7130

DOCTOR'S LIEN

PATIENT NAME _____

For good and valuable consideration received, I **(print name)** _____ being the undersigned, authorize and direct you, **(name of insurance)**

_____

to pay directly to **Marcum Chiropractic Clinic** any sums as may be due and owing this chiropractic office for services rendered me, both by reason of accident, or illness and/or by reason of any other bills that are due this chiropractic office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and/or accident benefits, workers' compensation benefits, or any other insurance benefits or reimbursement whatsoever for which you may be obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said chiropractic office.

In further consideration of the above-indicated treatment, I hereby give a lien to say office against any and all insurance benefits named herein, and any and all proceeds of any settlements, judgment, or verdict, which may be owed me as a result of the injuries or illness for which I have been treated by said office. This contract to act as an assignment of my rights and benefits to the extent of the office's charges for services provided herein.

I, the undersigned, further hereby authorize and direct my attorney, **(attorney's name)**

_____

when settlement or judgments is reached, to pay in full the chiropractic bills rendered for all treatment and services as a result of the injuries or illness for which I have been treated by said office and any other amounts which I may owe said office at that time.

In further consideration of the treatment rendered herein, I do hereby authorize the chiropractic office to furnish you, the above-indicated party, and a full report of my examination, diagnosis, treatment, prognosis, chiropractic bills and any other relevant information pertaining to my treatment.

I understand that by signing this document I am authorizing release of reports and information to the above-indicated party, which could include the responsible party's insurance company.

Furthermore, I authorize the chiropractic office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and medical authorization.

In the event any insurance company is obligated to make payments to me upon the charges made by this office for the service rendered and refuses to make such payments, I

hereby assign and transfer to this office any and all causes of action, claims, whether in law or equity that I might have or that might exist in my favor against such company, and authorize this office to prosecute said cause of action either in my name or in the office's name and further authorize this chiropractic office to compromise, settle or other wise resolve any claim or cause of action in its sole discretion herein as it relates to amounts owed this doctor.

I understand that I am directly and fully responsible to said office for all medical bills submitted by them for services rendered me and this agreement is made solely for said office's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees. Said medical payments are due on demand by the office. I further understand and agree that said assignment, lien and authorization do not constitute any consideration for the office to await payment and it may demand payments from me immediately upon rendering services at its option.

If the doctor's bill is more than 30 day past due, then I understand and agree to pay interest at the rate of 24 percent per annum on the unpaid balance until paid.

This agreement is irrevocable and is binding upon the heirs, executors and legal representatives of the undersigned. Wherefore, the undersigned has here unto set his hand this _____day of _____, 20____.

_____

Patient

ATTORNEY ACKNOWLEDGEMENT OF ASSIGNMENT, LIEN, AND AUTHORIZATION AND RELEASE OF MEDICAL RECORDS AND INFORMATION.

I, _____, attorney for the above-indicated patient hereby acknowledge receipt of the above assignment and lien and agree to protect said chiropractic office pursuant to above-indicated terms.

DATE: _____ **ATTORNEY:** _____

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Insurance Billing & Payment Policy

We are happy to accept your insurance! As a courtesy, we will verify insurance coverage and benefits, and bill private medical and/or auto insurance for your care in this office.

Any deductible, co-pay, or co-insurance is the sole responsibility of the patient and must be paid at the time of care or upon receipt of any statement issued from this clinic.

We will strive to obtain the most accurate information from any insurance company regarding coverage and benefit information. In the event that insurance will not cover charges incurred for care, they remain the responsibility of the patient. In that event we are happy to discuss payment options.

We also offer a time-of-service discount for patients who choose to pay out of pocket for their care.

Outstanding balances may be referred for collections or legal action in the event of default. Any and all expenses incurred in the attempt to settle debts are the sole responsibility of the patient.

If you have any questions regarding your billing or payment options please feel free to ask our staff!

I have read and understand this billing & payment policy:

Signature:_____ Date:_____

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Cancelation & Rescheduling Policy

(All canceled appointments must be rescheduled)

We strive to offer superior patient care and schedule appointments to ensure our providers are available to each patient exclusively. In order to allow staff to best serve our clients, cancelations must be made at least 24 hours before any scheduled appointment

In the event an appointment is not canceled with sufficient notice, we will consider the appointment missed and send a courtesy prompt to reschedule along with a reminder about our cancelation policy.

A fee of $25 may be charged to the patient for missed chiropractic and acupuncture appointments and a $30 charge will apply for missed massage appointments. These charges will be due at the next scheduled appointment before further care is rendered.

In the event of three missed appointments the patient may be referred to another clinic for further care.

I have read and understand this cancelation policy:

Signature_____ Date_____