MARCUM CHIROPRACTIC
4310 N. Interstate Ave.
Portland, OR 97217
P: (503) 235-7130 F: (503) 235-7134
marcumclinic@gmail.com

REGISTRATION FORM

(Please Print)

TODAY'S DATE: _____ WHO REFERRED YOU HERE?: _____

PATIENT LAST NAME: _____ FIRST: _____ MIDDLE: _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss MARITAL STATUS (circle): Single / Married / Divorced / Separated / Widowed

IS THIS YOUR LEGAL NAME? ☐ Yes ☐ No (Legal Name: _____) FORMER NAME: _____

DATE OF BIRTH: / / AGE: _____ SEX: ☐ M ☐ F

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NO: _____ HOME PH#: _____ CELL PH#: _____

EMAIL: _____ I prefer to receive correspondence by: ☐ Email ☐ Post ☐ Phone

RESPONSIBLE PARTY NAME (if minor): _____ RELATIONSHIP: _____

DATE OF BIRTH: / / ADDRESS: _____

HOME PH#: _____ CELL PH#: _____ WORK PH#: _____

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE (Not living at same address): _____

RELATIONSHIP TO PATIENT: _____ HOME PH#: _____ CELL PH#: _____

ACCIDENT INFORMATION (Complete boxed section ONLY if motor vehicle accident or Workers Compensation on-the-job injury)

DATE OF ACCIDENT: / / TYPE: ☐ WORK ☐ AUTO ☐ OTHER: _____

INSURANCE COMPANY: _____ CLAIM NUMBER: _____

ADJUSTER NAME: _____ PHONE #: _____

FAX #: _____ EMPLOYER NAME (if worker's comp): _____

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

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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: X_____ Date of Birth: X_____

Date and Time of injury: _____

Chief complaints (describe symptoms, include location): _____

_____

_____

Is it constant? Comes & goes? _____

Does it interfere with... (CIRCLE ALL THAT APPLY) 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(s) you are currently taking:

MEDICATION	VITAMINS/HERBS/MINERALS

X_____ X_____

Patient Signature Date

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BILLING & PAYMENT POLICY

For patients that do not have health insurance coverage, we offer a cash-rate due at the time of service.
We also offer payment plan options for patients who qualify.
It is the patient's responsibility to ensure that payments mailed arrive on or before the payment due date.

LATE FEES: Failure to pay agreed upon installments will result in a $25 late-fee, accrued bi-weekly.
Failure to make payments will result in the forwarding of your account to a collections agency, and your account will be subject to a continuance of the bi-weekly $25 late-fee accrual, as well as any interest and fees assessed by the aforementioned collections agency.
A breach or extension in the 3-month, 4-month, or 6-month payment plan agreement will result in a plan extension fee, with a 10% bi-weekly accrual applied to the account, in addition to the $25 late-fee.

PATIENT RESPONSIBILITY DISCLAIMER

The patient is responsible for payment of installments in a timely manner.
The patient is responsible for contacting Marcum Chiropractic in the event that the account may require a payment plan extension.
*Please note that an extension of a payment plan, timely or otherwise, may be assessed the above-mentioned fees and accruals.

You may make payments via telephone, by calling (503) 235-7130. You may also make payments in person, or write a check to:

MARCUM CHIROPRACTIC
4310 N. INTERSTATE AVE.
PORTLAND, OR 97217

I have read and understand this insurance billing & payment policy:

Signature X_____ Date X_____

CANCELLATION & NO-SHOW POLICY

Marcum Chiropractic aims to provide excellent care to our community of patients.
Our treatment plans set our patients up for success, and it is the patients responsibility to make sure they attend their appointments.

As courtesy to our providers and our other patients, Marcum Chiropractic requires patients to give a 24-hour notice if they are unable to make it to their appointment. Same-day cancellations will result in a $25 fee, due net-30 from the original date of the appointment.

We understand that life happens. Your first last-minute/same-day cancellation is on us.
After that, your account will be assessed a $25 fee, as noted above.

Please note that most insurance companies will not cover your cancellation and no-show fees.

I have read and understand this cancellation & no-show policy:

Signature: X_____ Date: X_____

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PATIENT CONSENT

Patient Name: X_____ **Date of Birth:** X_____

__ 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.

X_____ X_____ _____

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