ON THE MARK HEALTH AND WELLNESS

PATIENT REGISTRATION

Should we thank any individual for referring you to Loren Marks D.C.?		Date	
Full Name	DOB	Age	☐ Male ☐ Female
Address			
Home Telephone ☐ Primary Contact	Work Telephone ☐ Primary Contact	Mobile ☐ Primary Contact	
Social Security Number	Email Address		
Emergency Contact Name	Relationship	Emergency Contact Number	

INSURANCE INFORMATION

Primary Insurance Carrier	Group Number	ID Number
Primary Insured	Employer Name	
Business Address		
Employee Social Security Number	Employee Date of Birth	

FINANCIAL RESPONSIBILITY

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Name	Social Security Number
Address	
Telephone	Email Address

CREDIT CARD PAYMENT AUTHORIZATION

I _____, hereby authorize Loren Marks D.C. and/or On the Mark Health and Wellness or the staff at 200 West 57th St, Suite 1010 New York, N.Y 10019 to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify Loren Marks D.C. of any changes regarding credit card auth.

Name on Card	Signature/Date	
Credit Card Type ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express	Credit Card Number:	
Expiration Date	Security Code	Billing Zip Code

I attest, to the best of my knowledge, the above information is accurate and true.

Signature: _____ *Date:* _____

200 West 57th Street • Suite 1010 • New York NY 10019 • 212.333.7300 • Fax.212.399.9659

ON THE MARK HEALTH AND WELLNESS

CHIROPRACTIC AUTHORIZATIONS & ACKNOWLEDGEMENTS

While it is never our intention to bring anything of a potentially negative bent into a health and healing relationship, we, along with other health care providers and hospitals, are obliged by the state of New York to ask that you read and sign the following:

TREATMENT AUTHORIZATION: I (print name) _____ authorize Chiropractic Care, including spinal adjustment, of myself or my minor child by the Doctors and staff at Loren Marks D.C. and/or On the Mark Health and Wellness.

INFORMED CONSENT: Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

PRIOR CHIROPRACTIC TREATMENT INFORMATION

Name of Chiropractor:_____ Location (city): _____

When was your last treatment? _____ Have you had x-rays taken? _____

MEDICAL DOCTOR: Loren Marks D.C. and/or On the Mark Health and Wellness believe your medical doctor is a vital part of your healthcare team. As such, upon your request, we will send evaluations and progress reports to the physician listed below.

NAME: _____ **SPECIALTY:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE: _____ **FAX:** _____

ASSIGMENT OF BENEFITS: I authorize payment of my Medicare and/or insurance benefits to be made directly to Loren Marks D.C and /or On The Mark Health and Wellness on my behalf for services rendered. In the event my insurance carrier does not accept assigment of benefits, or of payments are made directly to me, I will endorse such payments to Loren Marks D.C and/ or On the Mark Health and Wellness within five (5) days of receipt of such payment.

FINANCIAL/ INSURANCE RESPONSIBILTY FOR ALL LOREN MARKS D.C AND / OR ON THE MARK HEALTH AND WELLNESS SERVICE: I understand and agree to the following policies regarding financial and insurance responsibilites. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibilty includes co-pay, co-insurance, deductible amount, and non- covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date to be unreasonable or not medically necessary. I further understand, Loren Marks D.C and / or On The Marks Health and Wellness will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Loren Marks D.C and / or On the Mark Health and Wellness to take action to secure payment of an outstanding blanace owed.

FURTHER NOTICES AS TO POLICIES REGARDING MEDICARE: Loren Mark D.C and /or On the Mark Health And Wellness is not a participating provider of Medicare, as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits to you. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider's office you are responsible to pay your deductible to Loren Marks D.C and /or On the Mark Health and Wellness. After your deductible is satisfied Medicare will reimburse you 80% of their standard fee for Chiropractic Adjustments only.

I understand that, in certain circumstances, Medicare may find that chiropractic treatments are not "reasonable and/or medically necessary" for the illness, injury of condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my doctor and their standards for that diagnosis. I understand that my reimbursement from Medicare is based upon their ruling.

NO GUARANTEES: I recognize that the practice of chiropratic is as much an art as a science, and therefore acknowledgment that no guaranties have been or can be made regarding the likelihood of success or outcome of any treatment and / or therapy rendered at Loren Marks D.C and / or On The Mark Health Wellness.

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me, writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I providfe to my doctors, therapists and insurance company is correct. I certify that I am here to receieve medical care and for no other purpose. I represent any third party.

By signing and dating this form I acknowledge I have discussed, or have had the oppurtinuty to discuss, with my doctor the nature and purpose of chiropractic treatment in general and my treatment in particular (uncluding my individualized plan of care as well as the contents of these acknowledgements and authorizations.

Patient Signiture_____ Date _____

ON THE MARK HEALTH AND WELLNESS

HIPAA NOTIFICATION
ELECTRONIC MAIL (EMAIL) COMMUNICATIONS

The goal of Loren Marks D.C. and/or On the Mark Health and Wellness is to make communication between you and our office as easy for you as possible. As such, you have the right to request that we communicate with you via electronic mail (email). However, prior to consenting to such communication, please take a moment to realize any and all privacy risks associated with this form of communication.

Email communications are two-way communication. However, responses and replies to emails sent to or received by either you or, Loren Marks D.C. and/or On the Mark Health and Wellness may be hours or days apart. As such, acute conditions should never be addressed using email communications.

Although Loren Marks D.C. and/or On the Mark Health and Wellness will make every effort to maintain privacy, email messages, on any device, have inherent privacy risks, as there is no way to ensure an email is completely tamper-resistant. That being said, you should not use email to discuss anything you wish to remain entirely confidential.

In order to forward and/or process and/or respond to your email, individuals at Loren Marks D.C. and/or On the Mark Health and Wellness, other than the intended recipient, may have access to or read your email message. Please remember, email communication is not a means of private communication.

This document, along with any and all email communications, may become part of your Loren Marks D.C. and/or on the Mark medical record.

PATIENT REQUEST FOR EMAIL COMMUNICATION

Please complete the information below if you wish to communicate Loren Marks D.C. and/or On the Mark Health and Wellness via email, knowing there are inherent privacy risks.

Patient Name:_____ Date of Birth: _____

Email Address: _____

Please initial each line and sign below:

_____ The email address contained herein is accurate, and I accept full responsibility for messages sent to or from this address.

_____ I have read, reviewed, and received a copy of this HIPAA Notification: Electronic Mail Communications.

_____ I understand and acknowledge that there are inherent privacy risks when communication is over the Internet.

I agree to hold Loren Marks D.C. and/or On the Mark Health and Wellness and its agents and representatives harmless from any and all claims and liabilities arising from or related to this Request for Email Communication.

Patient Signature:_____ Date:_____

ON THE MARK HEALTH AND WELLNESS

Acknowledgment of Receipt

NOTICE OF PRIVACY PRACTICES

By signing and dating this form, I acknowledge that I have received a copy of Loren Marks D.C. and/or On the Mark Health and Wellness notice of Privacy Practices.

Patient's Name *(Please print)*	Last four digits of your Social Security #
Patient's Signature	Date

If executed by a patient's personal representative, please complete the information in the space below:

Personal Representative's Name *(Please print)*	Relationship
Personal Representative's Signature	Date

If executed by a patient's legal guardian, please complete the information in the space below:

Legal Guardian's Name *(Please print)*	Relationship
Legal Guardian's Signature	Date