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:* _____

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

PROFILE

The following information is the basis for the relationship you are creating with your health counselor. Please complete this form as frankly as possible, know all information will be kept in the strictest of confidence. We look forward to guiding you on a successful journey to optimal health.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Blood Type _____

Occupation _____ Hours of work per week: _____

Marital Status _____ Do you have children? _____ Ages: _____

CURRENT HEALTH

What is the primary concern that prompted your visit?

_____

_____

Please list your secondary concerns?

_____

_____

Do you ever feel tired or weak? ☐ Yes ☐ No If so, please detail when this happens: _____

_____

Please list all supplements and/or traditional medication you are currently using:

_____

_____

_____

Please define the relationship and provide contact information for any holistic and/or traditional healthcare providers you are currently working with:

_____

_____

Please indicate if you have any of the following:

☐ Acne ☐ Ankle Swelling ☐ Backache ☐ Balance Issues ☐ Blood in Urine
☐ Burning During Urination ☐ Constipation ☐ Depression ☐ Diarrhea ☐ Dizziness
☐ Difficulty Holding Urine ☐ Dry Skin ☐ Dry Heels ☐ Fainting ☐ Headaches
☐ Joint Swelling or Stiffness ☐ Kidney Stones ☐ Leg Cramps ☐ Neck Pain or Stiffness
☐ Numbness ☐ Rashes ☐ Tingling in Extremities

Name: _____ Date: _____

MEDICAL HISTORY

Please detail any injuries, hospitalizations or serious health conditions:

_____

_____

DENTAL HISTORY

Please detail any general dental work you have had: _____

_____

Have you had your wisdom teeth removed? ☐ Yes ☐ No Were they impacted? ☐ Yes ☐ No

Do you bleach your teeth? ☐ Yes ☐ No How often? _____

MENTAL HEALTH

Do you have recurrent periods of depression? ☐ Yes ☐ No

Does anything specific bring on your depression? _____

_____

Do you experience notable anxiety? ☐ Yes ☐ No If so, when? _____

_____

Do you have issues with focus and concentration? ☐ Yes ☐ No o

WOMEN'S HEALTH

Are your periods regular? ☐ Yes ☐ No How many days is your flow? _____ Frequency: _____

Are your periods painful or symptomatic? ☐ Yes ☐ No How so? _____

Are you currently on birth control? ☐ Yes ☐ No What kind? _____

FAMILIAL HEALTH

Please detail the health issues of any immediate family member.

_____

_____

WEIGHT

Current: _____ Six Months Ago _____ One Year Ago _____

What is your goal weight? _____ When were you last your goal weight? _____

What is your motivation to change your weight? _____

Are you willing to modify your lifestyle to achieve your goal? ☐ Yes ☐ No

If so, what lifestyle changes do you think you need to make? _____

_____

_____

SLEEP

How many hours a night do you typically sleep? Weekdays: _____ Weekends: _____

Do you wake throughout the night? ☐ Yes ☐ No If so, how many times? _____

How long have you been waking throughout the night? _____

Do you have difficulty: falling asleep? ☐ Yes ☐ No waking up? ☐ Yes ☐ No

Name: _____ Date: _____

EXERCISE

Do you currently exercise? ☐ Yes ☐ No If so, please note your activities below:

Description of Activities	Frequency

Would you consider using a personal trainer? ☐ Yes ☐ No

HABITUATION

Do you currently smoke? ☐ Yes ☐ No If so, how much? _____ How often? _____

Do you drink alcohol? ☐ Yes ☐ No How much & often do you drink each of the following:

Wine: _____ Beer: _____ Liquor: _____

Do you drink coffee/soda? ☐ Yes ☐ No How much coffee? _____ How much soda? _____

Have you ever used narcotics, stimulants or depressants on a regular basis? ☐ Yes ☐ No

How long ago did you discontinue use? _____ If not, how often do you currently use? _____

EATING HABITS

What do you typically eat?

Breakfast	Lunch	Dinner	Snacks	Liquids

Have your eating habits changed in the past year? ☐ Yes ☐ No

What did you typically eat a year ago?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you have food cravings? ☐ Yes ☐ No If so, what do you crave? _____

What foods disagree with you? _____

How frequently do you eat? _____

What percentage of your food is home cooked? _____ Who cooks in your home? _____

Where is the rest of your food from? _____

ADDITIONAL INFORMATION

ON THE MARK HEALTH AND WELLNESS

HEALTH & WELLNESS AUTHORIZATION & ACKNOWLEDGEMENT

1. SERVICES: My health care provider has recommended functional, nutritional, and lifestyle evaluation, testing, consulting, and care, including dietary supplements. I understand and am informed that products and services are not provided by medical physicians and do not include prescription of legend drugs, surgery, or other conventional allopathic medical treatments. I further understand that consultations, evaluations, supplementation, lifestyle consultation, testing, recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients pertain to the functional health/whole body concept.

2. NO GUARANTEE: I have been informed that the methods of nutritional evaluation or testing made available to me are not intended to diagnose disease from an allopathic model of medicine. Rather, they are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor progress in achieving goals. I further understand that any recommendations are supportive in nature allowing the body to return to improved health. Like all other health care, results are not guaranteed and there is no promise to cure. Accordingly, I understand that payment(s) for services are not conditional on my response to care. Prorated fees for unused, prepaid services, however, will be refunded if I wish to cancel. No refunds will be available for any products purchased.

3. RISKS: I understand the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that may be recommended are generally considered safe, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I also understand that nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may interact with some legend drugs. Accordingly, I agree to consult with my prescribing physician about any legend drugs I am taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. I will inform my health practitioner if I experience gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, itching, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients.

4. PREGNANCY: I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner if I am or become pregnant.

5. ALTERNATIVES: I understand that the alternatives to the recommendations include doing nothing and/or seeking additional allopathic medical care.

6. QUESTIONS AND ANSWERS: I have read and fully understand this consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND THIS FORM!

I have read and fully understand this consent. All items have been explained, I have had sufficient time to evaluate the information, and my questions have been answered. Knowing the alternatives and risks, I consent to the services.

Signature _____ Date _____

Name (printed)_____