



NEW PATIENT REGISTRATION

Today's Date _____

Name _____ Acct# _____ Int _____
Last First MI

Address _____*
(Complete Mailing) Street Apt# City State Zip

Social Security # _____ - _____ - _____ Date of Birth _____

Primary Phone* (____) _____ - _____ home cell work

Secondary Phone* (____) _____ - _____ home cell work

Email Address: _____*

Employer _____ Occupation _____ Phone (____) _____ - _____

Emergency Contact _____ Relationship _____ Phone (____) _____ - _____

If applicable, who are you related to at UWS? _____

Relationship _____ Faculty Staff Student

Reason for this visit: routine accident, date _____ illness other: _____

* Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

I have read and understand that this alternative is available to me _____
Signature Date

RESPONSIBLE PARTY INFORMATION

Name (Guarantor) _____
Last First MI

Relationship to Patient _____

Address _____ Phone (____) _____ - _____
Street City State Zip

Employer _____ Address _____

Employer Phone (____) _____ - _____

Name of Insurance _____ ID# _____ Grp# _____

CONTINUED...

ACKNOWLEDGEMENT AND UNDERSTANDING

PLEASE READ AND INITIAL EACH ITEM BELOW.

1. _____ I hereby authorize Columbia Integrated Care to provide Chiropractic services for me.
2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Columbia Integrated Care.
3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.
4. _____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Columbia Integrated Care, 5847 NE 122nd Ave. Suite 104, Portland, OR 97230.
5. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

Patient Signature

Date

Guarantor Signature

Relationship to Patient

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

Patient's full name

Date of Birth

to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Signature _____ Witnessed by _____
(Parent or Legal guardian)