Synergy
CHIROPRACTIC &
WELLNESS CENTER

Adult Patient Questionnaire

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1 Confidential Patient Information

First Name _____ Last Name _____ Date _____

Social Security # _____ Date of Birth _____ Sex ❍ Male ❍ Female

Marital Status _____ Number of Children _____ Occupation _____

Street Address _____ Height _____ft _____inches

City _____ State _____ Zip _____ Weight lbs. _____

Email _____ Cell Phone _____ Other Phone _____

Emergency Contact _____ Emergency Relation _____ Emergency Phone _____

How did you hear about us? _____

Who is your primary care physician? _____

Date and reason for your last doctor visit? _____

Are you also receiving care from any other health professionals? ❍ Yes ❍ No

If yes, please name them and their specialty _____

Please note any significant family medical history _____

2 Current Health Condition

What health condition(s) bring you into our office? _____

Have you ever received care for this problem before? ❍ Yes ❍ No If yes, please explain _____

When did the condition(s) first begin? _____ How did the problem start? ❍ Suddenly ❍ Gradually ❍ Post Injury

Is this condition getting: ❍ Getting Worse ❍ Improving ❍ Intermittent ❍ Constant ❍ Unsure

What makes the problem better? _____

What makes the problem worse _____

3 Your Health Goals

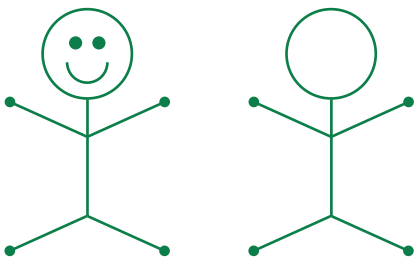
Your top three health goals:

1) _____

2) _____

3) _____

Indicate where you are experiencing pain or discomfort:



FRONT BACK

4 Chiropractic History

Have you ever visited a chiropractor? ❍ Yes ❍ No

What would you like to gain from chiropractic care? ❍ Resolve Existing Conditions ❍ Overall Wellness ❍ Both

Do you have any concerns for other family members today? _____

5 TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries, or other injuries as an adult? ❍ Yes ❍ No

Notable childhood injuries? ❍ Yes ❍ No If yes, please explain _____

Youth or college sports? ❍ Yes ❍ No If yes, please explain _____

Any automobile accidents? ❍ Yes ❍ No If yes, please explain _____

Exercise frequency? ❍ None ❍ 1-2 times per week ❍ 3-5 times per week ❍ Daily

What types of exercise? _____

How many hours do you sleep per night? _____

List any problems with flexibility (Example: putting on socks, shoes, etc.) _____

How many hours per day do you typically spend sitting at a desk or on a computer? _____

6 TOXINS: Chemical & Environmental Exposure

Please rate your consumption of each:

	None		Moderate		High		None		Moderate		High
Alcohol	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	Processed Foods	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5
Water	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	Artificial Sweetener	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5
Sugar	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	Sugary Drinks	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5
Dairy	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	Cigarettes	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5
Gluten	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	Recreational Drugs	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5

Please list any drugs, medications, vitamins, herbs, or other that you are taking and why: _____

_____

7 THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		Moderate		High		None		Moderate		High
Work	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	Finances	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5
Home	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	Health	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5
Life	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	Family	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5

8 Acknowledgement & Consent

Patient Name _____ Date _____

9 Financial Policy

Insurance Patients

Please note that your insurance coverage is a contract between you and your insurance company and that you are ultimately responsible for your bills at Synergy Chiropractic.

As a courtesy to our patients, Synergy Chiropractic will make every effort to verify chiropractic benefits. **Unfortunately, Synergy Chiropractic cannot guarantee that your insurance will pay benefits because insurance companies never guarantee payment until they review the claim.** Please realize that it is your responsibility to contact your employer or benefits office for details of personal coverage.

I understand that I am responsible for **all charges not covered by insurance** including, but not limited to: **all claims denied, unpaid due to deductibles, co-insurance/co-pay, out-of-network, and all charges denied from a completed review for medical necessity (eg. your insurance company does not feel that your condition is medically necessary)**. I further understand Synergy Chiropractic will honor all discounts, fee schedules, and network participation pricing as per signed contract. Discounts assigned by organizations or insurances without a signed agreement with Synergy Chiropractic will become the patient's responsibility. I hereby authorize and assign directly to Synergy Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

All co-pays are due at the time of service.

I understand that if my health insurance does not include coverage for chiropractic, I will be required to pay at the time of service. I further understand that I have the right to establish a payment plan when costs exceed my ability to pay. Payment Plan Contracts are available at the front office.

Claims not paid by your insurance company after 60 days are the responsibility of the patient, or in the case of a minor the parent/guardian.

Missed Appointment Fee

If a patient is a NO SHOW or does not make a courtesy call to notify our office of a cancellation, a $40 fee will be charged. This fee will not be submitted to your insurance and must be paid before a new appointment is scheduled.

Past Due Accounts

In the event your account is past due, a 1.5% late charge will be assessed on all invoices overdue 30 days and older.

Returned Checks

There will be a fee of $35 for any checks returned by your bank.

Cash Patients

Please note that you are ultimately responsible for your bills at Synergy Chiropractic.
Payment is always due at the time of service for any and all services and products, unless a Payment Plan Contract is filled out in advance.

I have read the above policy and understand the terms of payment for Synergy Chiropractic.

_____	_____
Patient Print Name	Patient Signature
_____	_____
Guardian / Patient Representative Print Name	Guardian / Patient Representative Signature
_____	_____
Relationship to Patient	Date

10 Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from their party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

_____ _____

Patient Print Name (Please Print) Relationship to Patient

_____ _____

Signature Date

11 Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

_____ _____

Signature Date

_____ _____

Guardian or Spouse Authorizing Care Signature Date

Who should receive bills for payments on your account?

Patient Spouse Parent Workers Comp Auto Insurance Medicare Health Insurance

12 Patient Payment Guarantee

If you do not have insurance, your balance is due at each visit.

I, _____ authorize Synergy Chiropractic to charge the credit card I have provided below in the event that I fail to make a payment on my account for 60 days or more.

_____
Signature of Patient

Credit Card Type: Visa MasterCard

Name on card: _____

Card Number: _____

Expiration Date: _____

3 digit security code: _____