

DR. DAVID KULLA, CHIROPRACTOR

Synergy Wellness -

New Patient Information

First Name _____ M.I. _____ Last Name _____
Sex _____ DOB _____ Social Security Number _____
Address _____
City _____ State _____ Zip _____ Phone (____) _____
E-Mail Address _____ Cell Phone _____

Insured

Insurance Company _____
First Name _____ M.I. _____ Last Name _____
Sex _____ D.O.B. _____ Social Security Number _____

Current Employer _____
Address _____ City _____ State _____
Zip _____ Group # _____ Phone (____) _____ - _____
Date of Injury _____ Time of injury _____

Is this injury due to an accident?

Auto Accident Work Comp Injury Other

How did your injury occur?

Have You Been Treated for this Problem in the Past: If Yes by Whom?

Name and Address of Primary Care Physician:

Assignment and Release-Signature on File

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and a interest fee of 10% will be added to any unpaid balance over 120 days. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Responsible Party Signature

_____ Date

_____ Relationship

For office use only: Tens _____ Trac _____ Declined _____

Health History

What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Place a check if you have **had** any of the following:

- | | | | |
|---------------------|------------------------|-------------------------|------------------------|
| AIDS/HIV _____ | Emphysema _____ | Miscarriage _____ | Scarlet Fever _____ |
| Alcoholism _____ | Epilepsy _____ | Mononucleosis _____ | Stroke _____ |
| Allergy Shots _____ | Fractures _____ | Multiple _____ | Suicide Attempt _____ |
| Anemia _____ | Glaucoma _____ | Sclerosis _____ | Thyroid _____ |
| Anorexia _____ | Goiter _____ | Mumps _____ | Problems _____ |
| Appendicitis _____ | Gonorrhea _____ | Osteoporosis _____ | Tonsillitis _____ |
| Arthritis _____ | Gout _____ | Pacemaker _____ | Tuberculosis _____ |
| Asthma _____ | Heart Disease _____ | Parkinson's _____ | Tumors _____ |
| Bleeding _____ | Hepatitis _____ | Disease _____ | Growths _____ |
| Disorders _____ | Hernia _____ | Pinched Nerve _____ | Typhoid Fever _____ |
| Breast Lump _____ | Herniated Disk _____ | Pneumonia _____ | Ulcers _____ |
| Bronchitis _____ | Herpes _____ | Polio _____ | Venereal Disease _____ |
| Bulimia _____ | High Cholesterol _____ | Prostate Problems _____ | Whooping Cough _____ |
| Cancer _____ | Kidney Disease _____ | Prosthesis _____ | Diabetes _____ |
| Cataracts _____ | Liver Disease _____ | Psychiatric Care _____ | |
| Chemical _____ | Measles _____ | Rheumatoid _____ | |
| Dependency _____ | Migraine _____ | Arthritis _____ | |
| Chicken Pox _____ | Headaches _____ | Rheumatic _____ | |
| | | Fever _____ | |

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking _____ Packs/Day _____
 Alcohol _____ Drinks/Week _____
 Coffee/Caffeine _____ Cups/Day _____
 High Stress Level _____ Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications

Allergies

Vitamins/Herbs/Minerals

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TERMS OF ACCEPTANCE

In the course of chiropractic health care, it is essential for the physician and patient to work together toward the same objective. As a patient, you should understand the goal and methods of chiropractic that will be used in order to avoid confusion or disappointment.

Health

This is a state of optimal physical, mental and social well-being, not just the absence of disease.

Vertebral subluxation

A misalignment of one or more of the 24 vertebrae in the spinal column causes alteration of the nerve function and interference of the transmission of mental impulses. Subluxation can impair the bodies' ability to achieve maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination we encounter non- chiropractic or usual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek a medical doctor who specializes in that area. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is adjusting to correct vertebral subluxation.

Adjustment

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

I _____ have read and fully understand the above statements.

All questions regarding the doctor' objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Signature

Date

DR. DAVID KULLA, CHIROPRACTOR

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THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient of Dr. Kulla, we may use or disclose personal and health related information about you in the following ways:

- *Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- *Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, PPO, or your employer (if they are or may be responsible for the payment of your services.)
- *Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.
- *If we are providing health care services to you based on the orders of another health care provider.
- *If we provide health care services to you in an emergency.
- *If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- *If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- *If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

We normally provide information about your health to you person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to

inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

If you would like further information about our privacy policies and practices please contact:

Patient Authorization requested for contact regarding chiropractic care and redemption of your free Birthday visit.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and for a free birthday visit.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care.

If you choose not to authorize this information use, your decision will have no adverse effect on your care from Dr. Kulla or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

Personal Representative (Printed) Personal Representative (Signature) Date

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed