Synergy Wellness
409 East 14th Street, Ste.C
New York, NY 10009
Tel: 212-533-4900 Fax: 212-533-4931

First Name_____________________ M.I. ________ Last Name __________________________
Sex M / F / Other: ________________ D.O.B__________ Social Security # ______________________
Address ____________________Apt______ City __________________State_____ Zip_________
Cell Phone (_____)_______________ Email Address_____________________________________

Emergency Contact
First Name, Last Name: ______________________________
Relationship: ______________________________
Phone Number: ______________________________

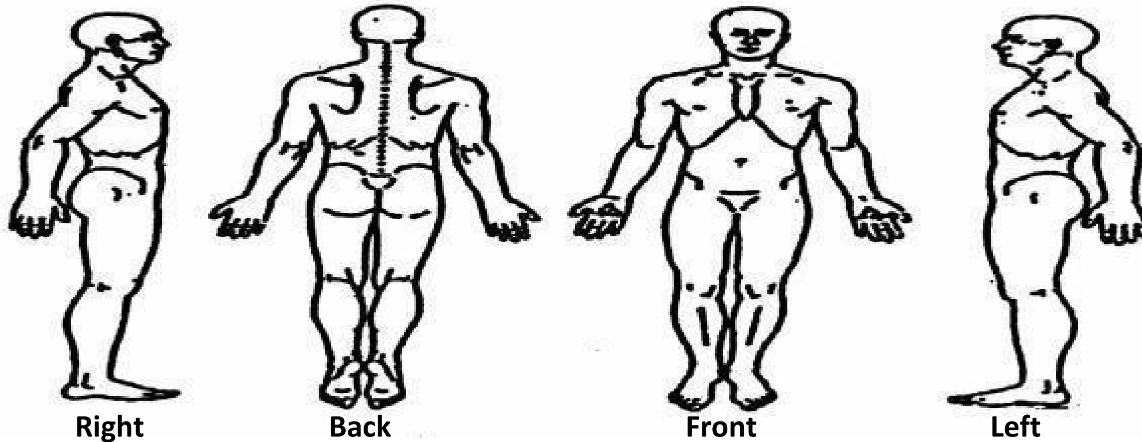
How did you hear about our office? ____
Name of Primary Care Physician: ____
Address of Primary Care Physician ____

Is this injury due to an accident? Yes / No
If yes, please fill out information below:

☐ Automobile Accident ☐ Worker's Compensation ☐ Other: ________________________
Date of Injury: ____________________
Time of Injury: ___________ AM/PM

Worker's Compensation ONLY:
Current Employer____
Address__________________________ City _______________ State ______ Zip _______
Phone (___) ______________

Please indicate on the drawings below where you have pain/symptoms



For Office Use Only:

MRI C / T / L **XRAY** C / T / L **EMG** C / L **PILLOW** C / L **DENNEROLL** C / T / L
LASER Yes/ No **TRACTION** Yes/ No **PHYSICAL THERAPY** Yes/ No
DME: ORTHCS / TENS / BB / CT
C INDEX: **BACK/HIP** **HEAD/NECK** **SHOLDERS** **ELBOW/WRIST/HAND** **FOOT/ANKLE/KNEE**
SCOLIOSIS **HIATAL HERNIA**

INS: _________________ DED: __________/MET__________ CO-INS:_________ SMT:____________

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1. How often do you experience your symptoms?
   - ☐ Intermittently (1-25% of the time)
   - ☐ Occasionally (26-50% of the time)
   - ☐ Frequently (51-75% of the time)
   - ☐ Constantly (76-100% of the time)

2. How would you describe the type of pain?

☐ Sharp	☐ Burning	☐ Tingly
☐ Dull	☐ Shooting	☐ Sharp with motion
☐ Diffuse	☐ Stiff	☐ Shooting with motion
☐ Achy	☐ Numb	☐ Other:__________

3. Using a scale from 1-10 (10 being the worst), how would you rate your problem?
   1 2 3 4 5 6 7 8 9 10 (*Please circle*)

4. How long have you had this problem?
   Day(s) ______ Week(s) _______ Month(s) _______ Year(s) ________

5. Do you consider this problem to be severe?
   ☐ Yes ☐ Yes, at times ☐ No

6. How are your symptoms changing with time?
   ☐ Getting worse ☐ Staying the same ☐ Getting better

7. How do you think you problem began? ____

8. Have you had any significant past trauma? ☐ Yes ☐ No
   If yes, how? ____

9. Have you ever been hospitalized? ☐ Yes ☐ No
   If yes, why? ____

10. What surgical procedures have you undergone?
    ____

11. What aggravates your problem? ____

12. What have you tried to alleviate your problem? _______________________________

13. How much has the problem interfered with you work?
    ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

14. What actives do you do at work?

☐ Sit:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Stand:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Computer work:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ On the phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Other:_____________	☐ Most of the day	☐ Half of the day	☐ A little of the day

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15. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

16. What type of social activities do you do? ____

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. What is your: Age _______ Height _______ (ft/in) Weight _______ (lbs)

19. What is your daily intake of the following?

☐ Caffeine _____ cups/day ☐ Alcohol _____ drinks/week ☐ Cigarettes _____ packs/day

20. List all prescription medications you are currently taking:

____

21. List all over the counter medications you are currently taking:

____

22. Who else have you seen for your problem?

☐ Primary Care Physician ☐ ER Physician ☐ Neurologist
☐ Chiropractor ☐ Orthopedist ☐ Massage Therapist
☐ Physical Therapist ☐ No one ☐ Other: ____________________

23. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Other: ____________

24. For each of these conditions listed below, please check in the "PAST" column if you have had the condition in the past. If you presently have a condition listed below, please check in the "PRESENT" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ Chronic Sinusitis	☐	☐ Dizziness
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorders	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss		
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite	☐	☐ High Blood Pressure
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Diabetes
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	☐	☐ Asthma
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Visual Disturbances
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder		**For Females Only**
☐	☐ Cancer	☐	☐ General Fatigue	☐	☐ Birth Control Pills
☐	☐ Tumor	☐	☐ Muscular Incoordination	☐	☐ Hormonal Replacement
☐	☐ Scoliosis	☐	☐ Other:	☐	☐ Pregnancy

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MISSED APPOINTMENT/ SAME DAY CANCELLATION & LATE POLICY

- We understand that there are times when you must miss your appointment due to true emergencies. However, when you do not call to cancel an appointment, you are preventing another patient from receiving our care.
  If you must cancel or reschedule your appointment, it is your responsibility to notify us.
  If an appointment is not canceled by Midnight the night **BEFORE** your scheduled appointment, you will be charged a **$35.00 fee**; this will not be covered by your insurance company and is not refundable. Please call the office/leave a voicemail, text of office line or send an e-mail to provide sufficient notice.
- We understand that delays can happen. However, we must try to keep the other patients and doctor on time. As a courtesy to our office, please call in advance if you know you will be late for your appointment. If a patient is 20 minutes late past their scheduled time, we will have to reschedule the appointment.

**Patients who miss three scheduled appointments with no previous notification may be discharged from the practice.*

PATIENT ACKNOWLEDGEMENT

You will be asked for a credit card at the time you check in/out. The information will be held on file electronically and securely. If you miss your appointment or cancel the same day of your appointment, we will charge the credit card on file ($35.00 fee) and email you your receipt.
If your insurance company denies coverage for services rendered or there is a deductible that has not been satisfied, you will receive a statement from our office. Once you have received this statement, it is your responsibility to make your payment promptly. If payment has not been received after 3 weeks from the initial statement, your credit card will be charged for the outstanding balance and a copy of the charge will be emailed to you. It is the patient's responsibility to understand how Out of Network benefits apply to their policy (ie: deductible, co-insurance, ect.)

Dr. David Kulla is an Out of Network provider for most insurance companies. As a courtesy, we submit the bills for the patient to help reduce your out-of-pocket costs in the office. It is customary for your insurance to send you an **Explanation of Benefits** regarding the claims filed for your office visit(s). Please let us know if you have any concerns regarding the Patient Responsibility portion, as you may not have a balance with the office.

***BLUE CROSS BLUE SHIELD PATIENTS**: It is customary for your insurance company to send the **SUBSCRIBER of the policy checks for reimbursement to our office.** Checks must be endorsed and returned to SYNERGY WELLNESS.

Please sign and date below.

By doing so, you understand the offices "Missed Appointment/ Same Day Cancelation, Late Policy", and Patient Acknowledgement.
I authorize Synergy Wellness to charge the "Missed Appointment/ Same Day Cancelation" **$35 fee** to the credit card on file, **AND** charge outstanding balances from my account to the credit card on file.

____________________________ ____________________

Signature **Date**

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	Patient Authorization Record
X______	**Authorization for Treatment** • I hereby give authorization for the performance of such rehabilitation & chiropractic procedures as permitted by New York State Statutes under the appropriate scope of practice are, in the judgment of my Doctor and/or Therapist, deemed necessary. • I have read "Notice of Privacy Practices" mandated by HIPAA. • I agree to pay Synergy Wellness charges for services rendered to me during my course of treatment. I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Synergy wellness collections costs including attorney and court fees. **Consent to Care** • A patient coming to the doctor gives his/her permission and authority to care for them in accordance with the appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from which would otherwise not come to the attention of the physician. I affirm that I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problem. * In the course of chiropractic 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. * 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 unusual 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 method is adjusting to correct vertebral subluxation. * 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.
	Insurance Policies Only
X______	**Authorization for Release of Payment and Information** • I authorize that direct payment of any benefits available to me be released to Synergy Wellness for services rendered. • I authorize the release of medical information necessary to obtain payment of any benefits available to me to Synergy Wellness for services rendered and Synergy Wellness may provide information from my medical records to persons involved in my medical care. • I agree that Synergy Wellness may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. **Medicare and Supplemental Insurance Benefits** • I agree that the information given to Synergy Wellness in applying for benefits under Medicare, and Maternal or Child Health services are complete and accurate. • I agree that Synergy Wellness may give Social Security Administration or its fiscal intermediary's information necessary to process claims. **Workers Compensation and No-Fault Cases** • I agree that the information given to Synergy Wellness in applying for benefits under Workers Compensation or No-Fault Automobile is complete and accurate. • I agree that Synergy Wellness may give intermediary's information necessary to process claims.