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_____ **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 _____

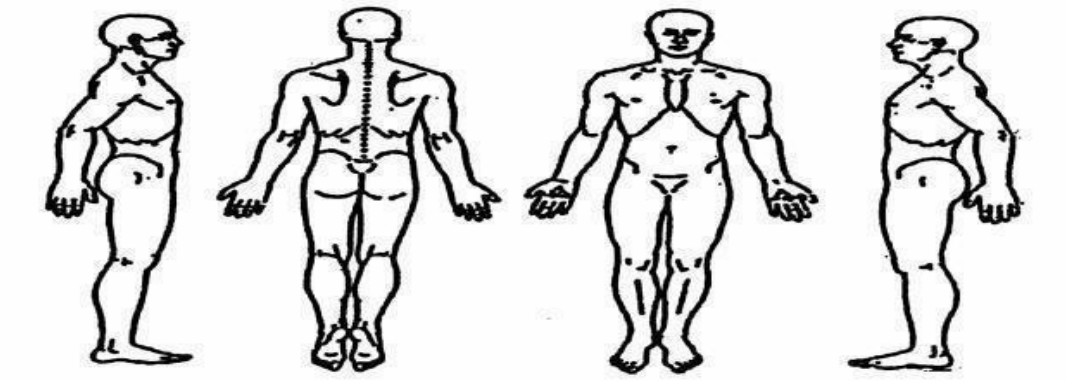
Is this injury due to an accident? **Yes / No**

☐ Auto Accident ☐ Worker's Comp ☐Other

Date of Injury_____ Time of Injury _____ AM/PM

Current Employer_____
Address_____ City _____ State _____ Zip _____
Phone (___) _____

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



For Office Use Only:
NOTES:

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MRI C / L / T **XRAY** C / L / T **EMG** C / L / T **PILLOW** C /L
LASER Yes/ No **TRACTION** Yes/ No **FUNC.EVAL**_____
ORTHCS Yes/ No **TENS / BB** **DENNEROLL** C / L / T
PHYSICAL THERAPY Yes/ No

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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 Dependen
□	□ 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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NO SHOW / SAME DAY CANCELLATION POLICY

Thank you for choosing the office of Dr. David Kulla. We appreciate your business.

We understand that there are times when you must miss your appointment due to emergencies or obligations for work or family.
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 at least 24 hours in advance you will be charged a $25.00 fee; this will not be covered by your insurance company and is not refundable.

- Calling the office, leaving a voicemail, or sending an e-mail is sufficient.

Patients who "No Show" with no previous notification three times for scheduled appointments may be discharged from the practice.

LATE POLICY

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 15 minutes late past their scheduled time we will have to reschedule the appointment.

Please sign and date below. Thank you for understanding the offices "No Show/ Same Day Cancelation/ Late Policy".

I authorize Synergy Wellness to charge the "No Show/ Same Day Cancellation" fee to the following credit card:

Name on Card: _____
Credit Card Number: _____
Expiration Date:_____
Security Code: _____

_____ _____
Signature **Date**

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EXPLANATION OF BENEFITS

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 E.O.B. regarding the claims filed for your office visit(s). There may be a patient responsibility listed. Please let us know if you have any concerns regarding the Patient Responsibility portion, as you may not have a balance with the office.

PATIENT ACKNOWLEDGEMENT

You will be asked for a credit card at the time you check in. The information will be held on file electronically and securely until your insurance has paid their portion and notified us of the amount you may share. If your insurance company denies coverage for services rendered, you will receive a statement from our office.
Once you have received this statement, it is your responsibility to contact the office to notify us of how to proceed with your payment. 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 mailed to you.

BLUE CROSS / BLUE SHIELD PATIENTS

Dr. David Kulla is an out of network provider for Blue Cross /Blue Shield. 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 company to send YOU checks for reimbursement to our office, which need to be endorsed and returned back to SYNERGY WELLNESS.**

I authorize Synergy Wellness to charge outstanding balances from my account to the following credit card:
(If this credit card is the same from the No Show/ Same Day Cancellation Fee Policy, please indicate "SAME CARD" and proceed to signature and date listed below)

Name on Card: _____
Credit Card Number: _____
Expiration Date:_____
Security Code: _____

Please sign and date below. Thank you for understanding.

_____ _____
Signature **Date**

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Patient Authorization Record

Initial here

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.
X_____	**Patient Agreement*** • 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.
X_____	**Authorization for Release of Payment (Insurance*)** I authorize that direct payment of any benefits available to me be released to Synergy Wellness for services rendered.
X_____	**Authorization for Release of Information (Insurance*)** • I agree that Synergy Wellness may provide information from my medical records to persons involved in my medical care. • I authorize the release of medical information necessary to obtain payment of any benefits available to me to Synergy Wellness for services rendered. • 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. I have read "Notice of Privacy Practices" mandated by HIPAA.
X_____	**Medicare Benefits and Supplemental Insurance** *(Only sign if you have Medicare)* • 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.
X_____	**Workers Compensation and No-Fault** *(Only sign if you have a W.C. or N.F. case)* • 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.

Required

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.

I have read and understand the consent to care.

_____

Patient Name Patient Signature Date

_____

Name Of Legal Representative/POA Signature of Legal Representative/POA Date

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TERMS OF ACCEPTANCE

In the course of chiropractic heath 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 the 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 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 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 doctors' objectives pertaining to my care in this office have been answered to my satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

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