SYNERGY WELLNESS CENTER

Confidential Patient History and Information

Name____ Date of Birth______________________ Age__________________

Address____ City__________________________ State__________ Zip__________

Home Phone_______________________ Cell Phone___________________ Email____

SSN_______________________ Gender______ Marital Status______ Spouse Name________________________ # of Kids______

Occupation_____________________________ Employer______________________________ Work Phone___________________

Name of Nearest Relative (emergency contact) _______________________________________ Phone_______________________

Who referred you to our office? ____

Is your visit due to an injury (car accident/on the job)? Yes No (If yes, please get an injury report from the front desk)

Briefly describe your symptoms____

Please list any medications and/or supplements you are currently taking____

____

List other doctors you see for your health care____

Previous chiropractor(s) ____

List any surgeries with date____

Height____________ Weight____________ Hobbies/Sports____

Do you have insurance? _______________ (If yes, please give your card to the front desk to verify benefits)

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

- ☐ Headache
- ☐ Neck Pain
- ☐ Stiff Neck
- ☐ Sleeping problems
- ☐ Back Pain
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Allergies

- ☐ Pins & needles in hands/arms
- ☐ Pins & needles in fees/legs
- ☐ Numb fingers
- ☐ Numb toes
- ☐ Digestive problems
- ☐ Constipation
- ☐ Asthma
- ☐ Diarrhea

- ☐ Fatigue
- ☐ Ears ringing
- ☐ Loss of balance
- ☐ Fainting
- ☐ Head heavy
- ☐ Cold hands/feet
- ☐ Sinus trouble
- ☐ Cancer

Female Only

- ☐ Painful menstruation
- ☐ Irregular cycle
- ☐ Breast problems
- ☐ Menopause

Are you pregnant?

☐ Yes ☐ No ☐ Not sure

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Synergy Wellness Center extends credit to me and I understand that if I suspend or terminate my care, fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors of Synergy Wellness Center and whomever they may designate as their assistants to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Signature____ Date_______________________________

SYNERGY WELLNESS CENTER

Confidential Patient History and Exam Notes

Patient Name____ Date of Birth___________________________

Provider Signature ____ Exam Date________________________

Merdidee Senick, D.C.

SYNERGY WELLNESS CENTER

Confidential Patient History and Information

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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 adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other that vertebral subluxation. However, if during the course of a chiropractic spinal 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 the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____, have read and fully understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I accept chiropractic care on this basis.

____

Patient Signature Date

SYNERGY WELLNESS CENTER

Wellness Becomes You

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

Synergy Wellness Center is required by law to maintain the privacy and confidentiality of your Protected Health Information (PHI) and to provide our patients with notice of our legal duties and privacy practices with respect to your Protected Health Information (PHI).

Disclosure of your Health Care Information:

Treatment
We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations (example):

"On occasion, it may be necessary to seek consultation regarding your treatment from other healthcare providers associated with Synergy Wellness Center."

"It is our policy to provide a substitute healthcare provider, authorized by Synergy Wellness Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situation."

Due to the nature of Synergy Wellness Center's open adjustment areas; others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentiality. At any time, you may request a private consultation with the doctor.

Payment
We may disclose your PHI to your insurance provider for the purpose of payment or healthcare operations (example):

"As a courtesy to our patients, we will submit an itemized statement to your insurance carrier for the purpose of payment to Synergy Wellness Center for healthcare services rendered. If you pay for your healthcare services personally, we will, as a courtesy to you, provide and itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the healthcare services received."

Worker's Compensation
We may disclose your health information as necessary to comply with State Worker's Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition in the event of an emergency or your death.

Public Health
As required by law, we may disclose your health information to public health authorities for the purpose related to: preventing or controlling disease, injury disability, reporting child abuse or neglect, reporting domestic violence, report to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to researchers conducting research that has been approved by the Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner, and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below:

"It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may send you a letter, post card or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Synergy Wellness Center sponsored fundraising or marketing events."

Change of Ownership
In the event that Synergy Wellness Center is sold or merged with another organization, your health information will become property of the new owner.

Your Health Information Rights

- You have the right to request restriction on certain uses and discloses of your health information. Please be advised, however, that Synergy Wellness Center is not required to agree to the restrictions you request.
- You have the right to have your health information received or communicated through alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and receive a copy of your health information.
- You have the right to request that Synergy Wellness Center amend your PHI. Please be advised, however, that Synergy Wellness Center is not required to agree to amend your PHI. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can dispute the denial.
- You have the right to receive an accounting of disclosures of your PHI made by Synergy Wellness Center.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to the Notice of Privacy Practices
Synergy Wellness Center reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such an amendment is made, Synergy Wellness Center is required by law to comply with this Notice. Any questions about this notice or if you want more information about your privacy rights, please contact the Office Manager by calling 425-357-1105. If he/she is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

Complaints
Complaints about your privacy rights or how Synergy Wellness Center has handled your health information should be directed to the Office Manager by calling 425-357-1105. If he/she is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave SW
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of August 15, 2012.

SYNERGY WELLNESS CENTER

Wellness Becomes You

Acknowledgment of receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

____ ____________________________

Print Patient Name Date

____

Patient/Parent Signature

SYNERGY WELLNESS CENTER

Wellness Becomes You

Consent to Leave Messages
Consent to leave messages/share information with family/friends

I understand that my healthcare information at Synergy Wellness Center is protected and I have received a copy of their Notice of Privacy Practices.

In order for Synergy Wellness Center to leave detailed messages on my voicemail or answering machine, I need to give permission to Synergy Wellness Center.

Consent to Leave Messages (please check box)

☐ Yes ☐ No

I consent to information regarding my (or my child's (under the age of 18)) test results or detailed appointment reminders/instructions to be left on my voicemail or answering machine.

Consent to Share Information with Family and/or Friends (please check box)

☐ Yes ☐ No

I wish family members and friends to have access to my healthcare information. The name(s) listed below are family members or friends whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my Protected Health Information will be provided without my signature on a Medical Records Release form.

NAME	RELATIONSHIP
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________

______________________________ ______________________________
Print Patient Name Date of Birth

______________________________ ______________________________
Patient/Parent Signature Date

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up-to-date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my Protected Health Information and cannot cancel actions taken or disclosures made while the designation is in effect.