New Patient Packet

Welcome to Agasar Family WellCare at Inner Spa. Our goal is to work with you to achieve your optimal health, whether that means getting out of pain, increasing your energy, detoxing your body, or taking your wellness to the next level. We want to provide you with the tools, knowledge and care to help you on your wellness journey to the health you desire.

In order to establish your current state of wellness and the overall function of your body, we need to assess and understand the root cause of your symptoms through a series of non-invasive examinations during your initial visit, which includes a full case history, nerve and muscle tests, postural analysis, functional movement assessment, and spinal x-ray review.

Prior to your first visit, we suggest the following simple steps leading up to your appointment time:

- No alcohol within 24 hours
- No exercise within 4 hours
- No caffeine or food within 4 hours
- Drink 16 oz to 32 oz of water within 2 hours

At the time an appointment is reserved, we ask that you **COMPLETE** all paperwork (xx pages, not including this one) **PRIOR** to your initial session. We also ask that you bring any recent x-rays or MRI and blood work reports you may have so we can refer to them as part of our case history.

Your initial assessment will take 45-60 minutes, so please allow sufficient time when scheduling your initial session. If you have time constraints, please contact our office prior to your visit to discuss.

In order to get the best possible initial assessment, we ask that you wear comfortable clothing that you can easily move in. Multiple layers or bulky items make it more difficult to complete your initial assessment.

PLEASE NOTE: We block special time for new patients, and therefore require a minimum of 24 hours advance notice to cancel or change an initial appointment. We will be happy to make changes to your appointment with more than 24-hours notice with no charge. If you cancel with less than 24-hours notice, the initial exam fee will be changed. If you are running late for your appointment, please contact the office at 215.550.6502 as late arrivals run the risk of requiring a rescheduled appointment.

Informed Consent

When a person seeks our care and when we accept a patient for such care, it is essential that they are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in any way, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care, and is necessary in emergency situations. Our approach recognizes that you get symptoms for a reason and attempts to find the cause of the symptoms and address the function of the whole body. This is how we define wellcare: focusing on the optimum function of the individual, and it is what we do in our office.

We provide various services in our office, including chiropractic care, massage therapy, colon hydrotherapy, detoxification and nutritional services, and wellness coaching. The purpose of chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine called vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called subluxations. Subluxations are the most common cause of nerve system interference (pinched nerve) and cause dysfunction to the tissue and organs that these nerves supply. With appropriate chiropractic care, these subluxations can be reduced and corrected to restore normal nerve function. A properly functioning nerve system is the foundation to good health.

Chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, minor fractures (although rare), and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

I understand that this office includes detoxification, nutritional and wellcare recommendations in the treatment of its patients. The goal of each of these services is to support the body to improve its overall health and not to treat a specific disease or symptom. I understand all medication changes must be made by my healthcare provider. I understand that nutritional and digestive supplements have been proven to be extremely safe when taken as directed. There is always a chance for an adverse reaction from any product. If I feel I am having a reaction to a product, I will stop using the product until I can discuss the matter. I understand these products are sold retail and there is a NO refund policy.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Agasar Famiy WellCare at Inner Spa have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby request and consent to treatment by any means, method and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

I understand and have been provided with the Practice information and policies, and that I have the right to review these prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent for professional care. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek care.

Name (printed) _____ Date: _____

Signature: Patient or Legal Representative _____
(Attorney/Guardian/Parent)

Office Policies & Financial Responsibility

Agasar Family WellCare at Inner Spa is pleased to accept your insurance assignment, as soon as the responsible party verifies your exact coverage. We will file forms to assist you in every way we can. It must be fully understood that the contract is between you and your insurance company. You are fully responsible for any amount that is not paid by your insurance, and agree to the following:

1. I hereby authorize AFWC to apply for benefits on my behalf for covered services rendered. I certify that all information given is correct, and authorize the release of all information, including medical information, for this or related claims.
2. I understand AFWC may bill me for services rendered upon denial of my insurance company, despite prior approval, and I agree to be fully and personally responsible for payment. I understand that AFWC will NOT enter into a dispute with my insurance company over my claim. If circumstances warrant, my insurance assignment may be withdrawn.
3. I understand that if my insurance company requires a referral, it is my responsibility to obtain the proper referral prior to my visit.
4. I understand that should my insurance company request additional information before making a payment, I will need to promptly response to them with the requested information.
5. I understand that if my insurance requires a co-pay, that co-pay is due at the time of my appointment and that AFWC does not bill insurance companies for such co-pays.
6. I understand there is a $30 fee for any returned checks.
7. I understand that any insurance balance over 60 days past due is subject to a late payment fee of 1.5% per month.
8. I agree to pay any collection and/or attorney fees that may arise as a result of any unpaid balance being forwarded to a collection agency and/or attorney to cause payment.
9. I understand that a late payment fee will be assessed if payment on any balance due is not received by the 10th of the month. Late payment fees are as follows: $15 if the balance is $0-$99.99; $25 if the balance is $100-$999.99; and $35 if the balance is $1,000 or more. "Balance due" is defined as previous balance on statement that shows a late fee.
10. I understand there is a missed appointment fee of $50 if I fail to call or give advanced notice per the Chiropractic Etiquette & Policies.
11. I understand that AFWC is a smoke-free office, and will abide by this policy.
12. I understand that my credit card will be held securely in my electronic file for any balance due, which includes any missed appointment fees.

I have read and understand these policies, requested a copy (if desired), and agree to these terms.

Patient Name _____ Date _____

Signature of Patient/Guardian

_____

Application for Care

Date: _____
Referred by: _____

Please **print clearly**. Please fill out forms **completely** and **accurately** to the best of your ability so we can quickly get you on the road to health. Thank you!

General Information

Patient's Name: _____ Phone #: ( ) --
Last First MI

Cell Phone #: ( ) -- Email: _____

Address: _____
Street City State Zip

SS# -- -- DOB: / / Age: _____

Gender: ☐ Male ☐ Female

Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you have insurance? ☐ Yes ☐ No

Employer: _____ Phone #: ( ) --

Occupation: _____

Address: _____
Street City State Zip

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact

Name: _____ Relationship: _____

Phone #: ( ) --

Insurance Information

Insurance Company: _____ Phone #: ( ) --

ID/Claim #: _____ Group #: _____

Insured's Name: _____ SS#: -- --

Insured's DOB: / /

Chiropractic benefits are quoted to us by your insurance carrier. The benefits are subject to the terms and provisions of your plan and are not necessarily a guarantee of payment.

1. I authorize my insurance benefits to be paid directly to Agasar Family Chiropractic LLC dba Agasar Family WellCare at Inner Spa.
2. I am financially responsible for any non-covered services.
3. I authorize the Practice to release medical information for billing.

Signature: _____ Date: / /

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Experience renewal. Naturally...

Accident Information

Is your condition due to an accident? ☐ Yes ☐ No Date of Accident: ___/___/___

Type: ☐ Auto ☐ Work ☐ Home Other (please describe): _____

****If this condition is due to an accident, we require you to complete our accident history form****

Medical History

Please list any significant conditions either diagnosed with or treated for over the course of your life:

_____

_____

_____

Please list any injuries or surgeries you have had over the course of your life:

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:

Please list any medications, herb or supplements you are taking and the reason for their use:

_____

_____

_____

Family History

Mother: ☐ Living ☐ Deceased List any medical issues: _____

Father: ☐ Living ☐ Deceased List any medical issues: _____

Check any issues common to your family: ☐ Cancer ☐ Diabetes ☐ Heart disease

☐ High blood pressure ☐ Stroke ☐ Arthritis ☐ Scoliosis ☐ Thyroid disease

☐ Osteoporosis ☐ Other (describe): _____

Social History

Do you have any children? ☐ Yes ☐ No If yes, how many and what ages? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____

Do you smoke? ☐ Yes ☐ No If yes, how much/often/long? _____

What do you do most of the day in your job: postures, positions and repetitive movements? _____

_____

On a scale of 1 to 10 (1=worst and 10=best), rate how well you think you are doing with the following:

___ Exercise ___ Sleep ___ Diet ___ Energy level ___ Daily water intake ___ Ability to manage stress

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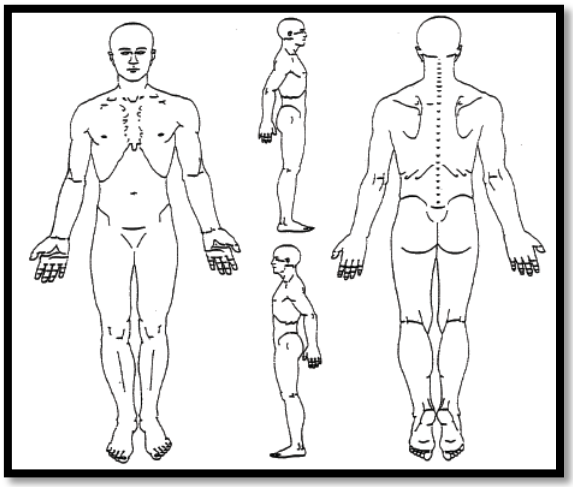
Your Visit

Please indicate the main reason you are seeing us today: _____

If you are seeing us for a pain-related issue, use the letter-key below to PLACE THE LETTER that describes the type of pain you feel in each location on the image to the right.

R = Radiating
D = Dull
N = Numbness
S = Sharp/Stabbing
B = Burning
A = Aching
T = Tingling



Using the pain scale to the right, CIRCLE the pain level you experience when your problem is at its very worst.

0 = No Pain. No discomfort.
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into your arms or legs? ☐ Yes ☐ No

Is there any numbness or tingling? ☐ Yes ☐ No

How often do you experience your problem? *(Please indicate for each of the body locations, as applicable.)*

☐ Constant (75%-100% of the time) ☐ Frequent (50%-75% of the time)
☐ Occasional (25%-50% of the time) ☐ Intermittent (0%-25% of the time)

List any MDs or Chiropractors you have already seen for this issue: _____

What tests have you already had for this problem? ☐ X-rays ☐ MRI ☐ Myelogram ☐ EMG/NCV ☐ None

What makes your problems worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Sneeze/Cough
☐ Changing position ☐ Lifting ☐ Bending ☐ Twisting ☐ Computer Work
☐ Going from Sit to Stand ☐ Reaching ☐ Sleeping ☐ Driving ☐ Telephone
☐ Other *(please describe)* _____

Review of Systems

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days.

0 = Never have the symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect not severe

Head: ____ Headaches ____ Faintness ____ Dizziness ____ Insomnia	**Energy/Activity:** ____ Fatigue/Sluggishness ____ Apathy/Lethargy ____ Hyperactivity ____ Restlessness	**Lungs:** ____ Chest Congestion ____ Asthma, Bronchitis ____ Shortness of Breath ____ Difficulty Breathing
Eyes: ____ Watery or Itchy Eyes ____ Swollen, Red or Sticky Eyelids ____ Bags/Dark Circles Under Eyes ____ Blurred or Tunnel Vision (not including near or farsightedness)	**Weight:** ____ Binge Eating/Drinking ____ Craving Certain Foods ____ Excessive Weight ____ Compulsive Eating ____ Water Retention ____ Underweight	**Heart:** ____ Irregular or Skipped Heartbeat ____ Rapid or Pounding Heartbeat ____ Chest Pain
Ears: ____ Itchy Ears ____ Earaches, Ear Infections ____ Drainage from Ear ____ Ringing in Ears, Hearing Loss	**Emotions:** ____ Mood Swings ____ Anxiety/Fear/Nervousness ____ Anger/Irritability/Aggressiveness ____ Depression	**Digestive Tract:** ____ Nausea, Vomiting ____ Diarrhea ____ Constipation ____ Bloated Feeling ____ Belching, Passing Gas ____ Heartburn ____ Intestinal/Stomach Pain
Nose: ____ Stuffy Nose ____ Sinus Problems ____ Hay Fever ____ Sneezing Attacks ____ Excessive Mucus Formation	**Mind:** ____ Poor Memory ____ Confusion, Poor Comprehension ____ Poor Concentration ____ Poor Physical Condition ____ Difficulty Making Decisions ____ Stuttering or Stammering ____ Slurred Speech	**Mouth & Throat:** ____ Chronic Coughing ____ Frequent Need to Clear Throat ____ Sore Throat, Hoarseness ____ Swollen or Discolored Tongue ____ Canker Sores
Skin: ____ Acne ____ Hives, Rashes, Dry Skin ____ Hair Loss ____ Flushing, Hot Flashes ____ Excessive Sweating	**Joints/Muscles:** ____ Pain or Aches in Joints ____ Arthritis ____ Stiffness or Limited Movement ____ Pain or Aches in Muscles ____ Weakness or Fatigued Muscles	**Other:** ____ Frequent Illness ____ Frequent or Urgent Urination ____ Genital Itch or Discharge

Quadruple Visual Analogue Scale

Please read carefully.
Directions: Please circle the number that best describes the question being asked.
Note: If you have more than one complaint, please answer the question for each individual complaint and indicate the score for each complaint.

1. What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

2. What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

3. What is your pain level AT ITS BEST? (How close to "0" does your pain get)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

4. What is your pain level AT ITS WORST? (How close to "10" does your pain get)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Other Comments:

Reprinted from *Spine*, 18, Von Korff M, Deyo RA,Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1year, 855-862, 1993.

I hereby authorize payment to be made directly to Agasar Family Chiropractic (dba Agasar Family WellCare at Inner Spa) for all benefits which may be payable under the healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Agasar Family Chiropractic LLC for any and all services I receive at this office.

Patient or Authorized Person's Signature

Date Completed

Doctor's Signature

Date Form Reviewed