Today's Date:_____

Confidential Patient Intake Form

Information contained in this form is considered strictly confidential. Your responses are important to better understand the health issues you face and ensure the delivery of the best possible treatment.

Name:_____ Date of Birth:_____ Age:_____ □ Male □ Female

What would you prefer to be called in our office?_____

Address:_____ City/ State:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____

Email:_____ Occupation:_____ Employer:_____

Marital Status: □ S □ M □ D □ W Social Security #:_____

Emergency Contact: Name:_____ Relationship:_____ Phone:_____

How did you hear about us?_____ May we send you our online newsletter? □ Yes □ No

Give a brief detailed description of the problem you are currently experiencing:_____

_____

_____

What seemed to be the initial cause?_____

When did this condition begin?_____ Is this condition: □ Getting Worse □ Better □ Same

Is this condition interfering with: □ Work □ Sleep □ Daily Routine □ Other:_____

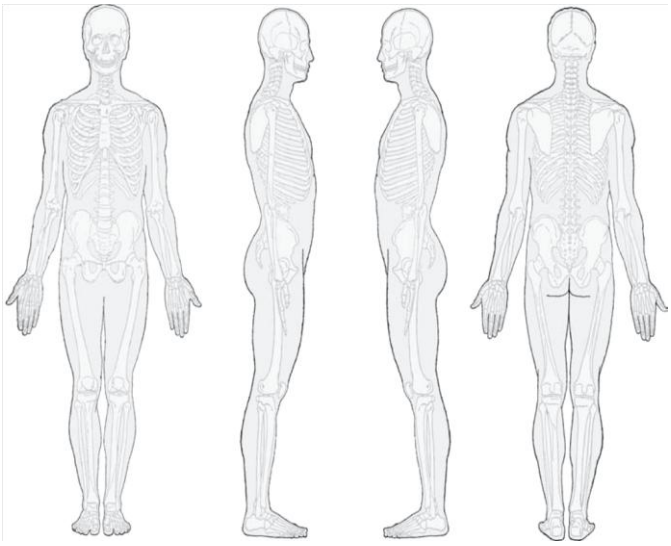
Have you had this or similar conditions in the past? □ Yes □ No, comments:_____

What seems to make this problem better?_____ worse?_____

Other issues you would like addressed:_____

Please indicate your area/s and type/s of pain on the figure below:

Numbness ---------- Pins & Needles oooooooooo Burning xxxxxxx Aching ******** Stabbing //////////////



Please place a mark at the level of your pain on the scale below:

No Pain ——————————— Worst Possible Pain

Other doctors or therapists that have treated *this* condition:_____

Have you been given a diagnosis? □ Yes □ No; if yes, what was it?_____

Family physician's name (if you have one):_____ Date of Last Physical Exam:_____

Was this a result of a work related or auto injury? □ Yes □ No, comments:_____

Review of Health History

Name:_____

Please check the corresponding boxes if you have the condition *now* or have had it in the *past*:

General	Now	Past
01. Weakness	□	□
02. Fatigue	□	□
03. Fever	□	□
04. Chills	□	□
05. Night Sweats	□	□
06. Fainting	□	□
Skin		
07. Color Changes	□	□
08. Nail Changes	□	□
09. Hair Changes	□	□
10. Moles	□	□
11. Rashes	□	□
12. Eczema	□	□
13. Psoriasis	□	□
14. Acne	□	□
Head		
15. Headache	□	□
16. Injuries	□	□
17. Bumps	□	□
18. TMJ Dysfunction	□	□
Eyes		
19. Last Eye Exam_____		
20. Glasses	□	□
21. Contact Lenses	□	□
22. Cataracts	□	□
23. Glaucoma	□	□
24. Change in Vision	□	□
Ears		
25. Deafness	□	□
26. Ringing	□	□
27. Discharge	□	□
28. Ear ache	□	□
29. Dizziness	□	□
30. Vertigo	□	□
Nose		
31. Decreased Smell	□	□
32. Bleeding	□	□
33. Pain	□	□
34. Discharge	□	□
35. Obstruction	□	□
36. Runny Nose	□	□
37. Sinus Congestion	□	□
Mouth		
38. Bleeding Gums	□	□
39. Sores	□	□
40. Dental Problems	□	□
41. Bad Breath	□	□
42. Loss of Taste	□	□
43. Dry Mouth	□	□
Throat		
44. Soreness	□	□
45. Tonsillitis	□	□
46. Hoarseness	□	□
47. Trouble Swallowing	□	□
48. Recurrent Infection	□	□

Neck	Now	Past
49. Stiffness	□	□
50. Soreness	□	□
51. Enlargement	□	□
52. Lumps / Masses	□	□
Respiratory		
53. Chronic Cough	□	□
54. Phlegm	□	□
55. Cough Up Blood	□	□
56. Short of Breath	□	□
57. Wheezing	□	□
58. Difficult Breathing	□	□
59. Chest Pain	□	□
Cardiovascular		
60. Murmur	□	□
61. Palpitation	□	□
62. Rapid Pulse	□	□
63. Swollen Ankles	□	□
64. Cold Hands/Feet	□	□
65. Varicose Veins	□	□
66. Blood Clots	□	□
67. Blue Hands/Feet	□	□
68. High BP	□	□
69. Low BP	□	□
Blood		
70. Anemia	□	□
71. Low Iron	□	□
72. Bruise Easily	□	□
73. Bleeding Disorder	□	□
74. Swollen Nodes	□	□
75. Tender Nodes	□	□
76. High Blood Sugar	□	□
77. Red Spots	□	□
Gastrointestinal		
78. Abdominal Pain	□	□
79. Nausea	□	□
80. Bloating	□	□
81. Belching	□	□
82. Heartburn	□	□
83. Indigestion	□	□
84. Constipation	□	□
85. Diarrhea	□	□
86. Undigested Food	□	□
87. Gas	□	□
88. Hemorrhoids	□	□
89. Poor Appetite	□	□
90. Food Intolerance	□	□
91. Bloody Stool	□	□
92. Black/ Tarry Stool	□	□
93. Diverticulitis	□	□
94. Vomiting	□	□
95. Vomiting Blood	□	□
96. Colitis/ Crohn's	□	□
97. Ulcers	□	□

Genitourinary	Now	Past
98. Urgency	□	□
99. Bed-Wetting	□	□
100. Incontinence	□	□
101. Frequent Voiding	□	□
102. Bladder Infection	□	□
103. Kidney Infection	□	□
104. Blood in Urine	□	□
105. Kidney Stones	□	□
106. Discharge	□	□
107. Painful Urination	□	□
Women Only	**Now**	**Past**
108. Lumps in Breast	□	□
109. Hot Flashes	□	□
110. Menopause	□	□
111. Vaginal Discharge	□	□
112. Vaginal Itching	□	□
113. PMS	□	□
114. Irregular Periods	□	□
115. Spotting	□	□
116. Uterine Fibroids	□	□
117. Age at First Menses:_____		
118. Length of Cycle:_____		
119. Days of Flow:_____		
120. Color:bright red/ dark red/pale red/brown		
121. Clots: □ yes □ no		
122. Birth Control Type:_____		
123. # of Pregnancies:_____		
124. # of Births:_____Miscarriages:_____		
125. Date of Last Period:_____		
126. Are you pregnant? □ yes □ no		
127. Trying to get pregnant? □yes □ no		
128. Date of Last PAP:_____		
□ normal □ abnormal		
129. Date of Last Mammogram:_____		
□ normal □ abnormal		
Men Only	**Now**	**Past**
130. Testicular Mass	□	□
131. Date of Last Prostate Exam:_____		
□ normal □ abnormal		
Neurological	**Now**	**Past**
132. Seizures	□	□
133. Tremors	□	□
134. Loss of Sensation	□	□
135. Incoordination	□	□
136. Paralysis	□	□
137. Numbness	□	□
138. Tingling	□	□
139. Loss of Memory	□	□
Endocrine	**Now**	**Past**
140. Weight Loss	□	□
141. Weight Gain	□	□
142. Heat Intolerance	□	□
143. Cold Intolerance	□	□
144. Hyperthyroidism	□	□
145. Hypothyroidism	□	□

Review of Health History (continued)

Name:_____

Please check the corresponding boxes if you have the condition *now* or have had it in the *past*:

Musculoskeletal	Now	Past
146. Muscle Pain	□	□
147. Muscle Cramps	□	□
148. Muscle Weakness	□	□
149. Muscle Twitching	□	□
150. Joint Stiffness	□	□
151. Arthritis	□	□
Type:_____		
152. Bursitis	□	□
153. Foot Trouble	□	□
Explain:_____		

Musculoskeletal	Now	Past
154. Low Back Pain	□	□
155. Middle Back Pain	□	□
156. Neck Pain	□	□
157. Hand Pain	□	□
158. Wrist Pain	□	□
159. Elbow Pain	□	□
160. Shoulder Pain	□	□
161. Foot Pain	□	□
162. Ankle Pain	□	□
163. Knee Pain	□	□
164. Hip Pain	□	□

Psychiatric	Now	Past
165. Hyperventilation	□	□
166. Eating Disorder	□	□
167. Depression	□	□
168. Irritability	□	□
169. Anxiety	□	□
170. Nervousness	□	□
171. Extreme Worry	□	□
172. Hallucinations	□	□
173. Alcoholism	□	□
174. Drug Addiction	□	□
175. Sexual Problems	□	□

Please check the corresponding box if you have had any of the following conditions:

176. Measles	□ yes	188. COPD	□ yes	200. Diabetes	□ yes
177. Mumps	□ yes	189. Asthma	□ yes	201. Appendicitis	□ yes
178. Rheumatic Fever	□ yes	190. Pneumonia	□ yes	202. Multiple Sclerosis	□ yes
179. Chicken Pox	□ yes	191. Tuberculosis	□ yes	203. Osteoporosis	□ yes
180. Cancer	□ yes	192. Liver Trouble	□ yes	204. Epilepsy	□ yes
181. Tumor	□ yes	193. Hepatitis	□ yes	205. Mental Illness	□ yes
182. Angina	□ yes	194. Gall Stones	□ yes	206. Migraine	□ yes
183. Heart Disease	□ yes	195. Parasites	□ yes	207. Syphilis	□ yes
184. Stroke	□ yes	196. Malaria	□ yes	208. Gonorrhea	□ yes
185. Arteriosclerosis	□ yes	197. Blood Disease	□ yes	209. Herpes	□ yes
186. High Cholesterol	□ yes	198. Gout	□ yes	210. HIV / AIDS	□ yes
187. Emphasema	□ yes	199. Goiter	□ yes		

Surgeries/Injuries/Serious Illnesses:_____

_____

_____

Medications / Vitamins / Supplements (include dosages):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies:

_____

_____

_____

_____

_____

_____

_____

Immunizations/ Vaccinations		Blood Type
DPT	□ yes	□ A+
MMR	□ yes	□ A-
Smallpox	□ yes	□ B+
Typhoid	□ yes	□ B-
Meningitis	□ yes	□ AB+
Influenza	□ yes	□ AB-
Polio	□ yes	□ O+
Hepatitis	□ yes	□ O-

Review of Health History (continued)

Name:_____

Family History: please fill in the following information

Relative	Age (If Living)	Age at Death	Cause of Death	Illnesses
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

Social History: please check the box that most accurately represents you or fill in the blanks

Mental Work: □ none □ light □ moderate □ heavy
Physical Work: □ none □ light □ moderate □ heavy
Exercise: days per week:_____
Type/s:_____
_____

Sleep: hours per night:_____
Quality: □ poor □ fair □ good □ excellent
Difficulty Falling Asleep? □ yes □ no
Frequent Waking? □ yes □ no, if so what time/s?_____
Dream-Disturbed? □ yes □ no

Past Occupational History:

_____ _____

_____ _____

Please indicate usage per day or per week of the following:

Water: _____ glasses per day □ room temp. □ cold
Coffee: _____ cups per day/week (circle)
Tea: _____ cups per day/week (circle)
Alcohol: _____ drinks per day/week (circle)
Type: □ beer □ wine □ liquor

Soft Drinks:_____ per day/week □ regular □ diet
Juice: _____ per day/week (circle)
Sweets: _____ per day/week (circle)
Cigarettes: _____ packs/day for ___ years
Have you ever smoked in the past? □ yes □ no

Please describe your average daily diet. Be specific.

Morning: _____
Snack: _____
Lunch: _____
Snack: _____
Dinner: _____

Please describe your energy levels:

How is your energy? (Please circle) ***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***
What time of day is your energy *highest*? □ 6am – 12pm □ 1pm – 5pm □ 6pm – 12am
What time of day is your energy *lowest*? □ 6am – 12pm □ 1pm – 5pm □ 6pm – 12am

Patient's Signature_____ Date_____ consistency taking supplements_____%

7 PILLARS OF HEALTH SURVEY OF YOUR BODY'S SYSTEMS

Rate 1-10 severity of any symptom you have experienced in last 6 MONTHS.

Neuro-hormonal/ Endocrine Pillar #1

Adrenals
___ Energy Low /Normal/ High
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Slow to Start in Morning
___ Energy Crash_____am/pm
___ Dizzy when stand quickly
___ Light Bothers Eyes
___ Weak Nails
___ Perspire easily or excessively
___ Orgasm Quality (poor/ good/ great)
Other_____

Pituitary
___ Sex Drive Low/ Normal/ High
___ Menstrual Disorders
___ Splitting Headaches
Other_____

Thyroid
___ Tired/Sluggish
___ Chills, Feel Cold hands, feet, body
___ Require Excessive Sleep
___ Increase in weight unexplained
___ Difficult infrequent bowel movements
___ Depression Lack of Motivation
___ Hair Loss and Thinning
___ Thinning of Outer Third of Eyebrow
___ Dryness of Scalp
___ Mental Sluggishness
___ Heart Palpitations-Skip/Flutter
___ Inward trembling
___ Increase pulse at rest
___ Insomnia-cannot sleep
___ Night Sweats
Other_____

Uterus (women only)
Last Menstrual Period_____
Length of Menses_____
___ Regular cycle
___ Irregular cycle
___ Early (less than 28 days)
___ Late (more than 28 days)
___ Skip cycle
___ Flow (heavy/ moderate/ light)
___ Cramps (mild/ mod/ severe)
___ Clotting/ Spotting
___ Headache side of head
Other_____

Ovaries (women only)
___ Sex drive Flat / Low/ Normal
___ Low Abdominal Puffiness
___ Fluid Retention Face / Hands / Feet
___ mood swings/irritable/depression
___ Tired during cycle
___ Ovarian pain
___ Breast Tender around cycle
___ Acne around cycle (pre/mid/post)
___ Birth Control Pill / Patch
___ Menopausal Natural /Surgical
___ Hot Flashes
___ Facial Hair growth
___ Dark Nipple Hair
___ Hair growing up towards belly button
___ Skin Crawling
___ Breast discharge
___ Breasts shrinking
___ Breast Feeding
___ Breast Surgery
Other_____

Vagina (women only)
___ Burn
___ Itch
___ Dry
___ Discharge-clear white yellow green brown
___ Pain with Intercourse
Other_____

Testes (Men)
___ Sex drive Flat / Low/ Normal
___ Decreased morning erections
___ Decreased fullness erections
___ Inability to concentrate
___ Episodes of depression
___ Decreased physical stamina
___ Sweating Attacks
___ More emotional than past
___ Unexplained weight gain
Other_____

Sleep
Quality (poor/fair/good/great)
___ ____ Hours in bed
___ ____ Hours asleep
___ Interrupted ___ per night
___ Awaken Suddenly (Jolt)
Other_____

Emotions
___ Stress
___ Sad
___ Grief
___ Depression
___ Moodiness
___ Frustrated
___ Irritable
___ Angry
___ Worrisome
___ Nervous
___ Anxiety
___ Panic
___ Cry
___ Fear
___ Shame
___ Guilt
Other_____

Brain
___ Forget Names
___ Forget Numbers
___ Forget Words
___ Forget Actions
___ Difficulty Focus/ Concentrating
Other_____

Exercise
Cardiovascular _____ times/ week
Weight Train _____times/per week

Glycemic Management Pillar #2

Pancreas
___ Crave Sweets
___ Irritable when skip meals
___ Light headed skip meals
___ Eating relieves fatigue
___ Bouts of blurred vision
___ Fatigue after meals
___ Frequent Urination
___ Increased Thirst
___ Difficulty losing weight
Other_____

Appetite / Diet
___ Appetite (Low, Norm, High)
___ Eat Animal Protein_____/per day
___ Eat Starch (pasta/bread/potatoes/rice)
___ Eat Sweets (cakes, cookies, candy)
___ Eat Chocolate_____/per week
___ Eat Spicy Foods_____/per week
___ Eat Ice Cream_____/per week
___ Coffee _____cups/ week
___ Caffeinated Tea _____cups/week
___ Juice _____per week
___ Soda _____per week
___ Beer _____per week
___ Wine_____per week
___ Liquor _____per week
___ Avoid Artificial Sweeteners_____%
___ Avoid Trans Fats _____%
Avoid Food Allergens _____%
Special Diet?_____

Bioterrain/ Mineral Pillar #3
___ Twitching around eyes
___ Difficulty falling asleep
___ Restlessness
___ Don't Remember Dreams
___ Nails spots or weakness
___ Air Hunger/ frequent sighs
___ Cramps (legs/feet/arms/hands)
___ Aches (legs/feet/arms/hands)
___ Restless (legs/feet/arms/hands)
___ Frequent Thirst
___ Shallow rapid breathing
___ Poor muscle endurance
___ Swelling in ankles and wrists
___ Uterine cramps women
___ Urination leakage
Other_____

Inflammatory / Immune Pillar #4

Eyes
___ Burn / Red /Dry
___ Tears
___ Eye Film /Crust in morning
___ Floaters
___ Stye
___ Itchy Eyes
___ Eye Ache
___ Vision blurry
___ Tired
___ Spots
___ Puffy
___ Dark Circles

Ears
___ Ear Noise (Ring/Hiss/Pound)
___ Ear Plugged
___ Ear Popping
___ Ear Ache / Infections
___ Ears Itch internally
___ Ear Drainage
___ Hearing Loss
___ Excessive Ear Wax
___ Dizziness/ Vertigo

Sinus
___ Frontal headache
___ Sinus dry
___ Sinus drain
___ Sinus stuffy
___ Sneeze frequent
___ Smell / Taste Loss
___ Post nasal drip
___ mucous: clear/white/yellow/green/brown

Lungs
___ Chest Congestion
___ Pain on Breastbone
___ Breath short on exertion
___ Wheezing
___ Asthma
___ Emphysema
___ Bronchitis

Mouth/ Throat/ Immune
___ Blisters
___ Canker Sore
___ Bad Breath
___ Bleeding gums
___ Receding gums
___ Teeth Health Problems
___ Dry Mouth
___ Swelling of Glands
___ Difficulty Swallowing
___ Sore Throat
___ Hoarseness
___ Fever
___ Cough (dry/productive)
___ Frequent Colds/ Flu
___ Environmental Allergies
___ Nightmares

Bladder
Urinate _____times per day awkake
___ Urinate at night _____ per night
___ Urination urgency
___ Burning /Pain urination
___ Cloudy urine
___ Odor urine
___ Spasm urinate
___ Urinary Tract Infection
___ Kidney Pain or Infections
Other_____

Skin
___ Skin Rash
___ Acne
___ Itchy Skin
___ Cellulite
___ Nail fungus (mild/mod/severe)

Breasts
___ Breast fibrosis
___ Breast Lumps
Other_____

Prostate (Men)
___ Urination difficulty
___ Frequent urination
___ Urination Burn / Achiness / Pain
___ Urination Dribbling /Emission/ Swelling
___ Pain inside of legs or heels
___ Leg twitching at night
___ Urination Dribbling /Emission/ Swelling
___ Headache side of head
Other_____

Cardiovascular Pillar #5
___ Chest Tension/ Tight/ Pressure
___ Chest Heaviness
___ Chest Heart Pain
___ Heart Palpitations-Skip/Flutter
___ Heart Racing
___ Heart Slowing down
___ Sleep Apnea
___ Mitral Valve Prolapse
___ Murmur
Other_____

Digestion Pillar #6

Stomach
___ Heartburn
___ Indigestion
___ Stomach Aches
___ Stomach Cramps
___ Nausea/ Queasy
___ Bloat after Eat
___ Gas/ Flatulence
___ Belching
___ Ulcer
___ Hiatal Hernia
Other_____

Liver/ Gallbladder
___ Headaches at base of skull
___ Greasy high fat foods cause distress
___ Difficulty losing weight
___ Dry or Itchy Skin
___ Patches skin look different
___ Yellow cast to eyes
___ Stool color clay colored
___ History of gallbladder attacks
___ Excessively foul smelling sweat
___ Hormonal imbalances

Hemorrhoids
___ Swollen/ Distended / Bloody Anus
___ Burning Anus
___ Itchy/ Stingy Anus
___ Achy Anus

List Your Primary Concerns in order of importance to you:
1)_____
2)_____
3)_____
4)_____

Bowels
___ Bowel Movements_____ Per day
___ Regular
___ Incomplete
___ Skip days _____ per (week/month)
___ Sluggish bowels every _____ days
___ Cramps in Abdomen
___ Taking Laxatives
___ Using Suppositories
___ Enemas
___ Colonics
___ Pain with Bowel Movements
___ Irritable Bowel Syndrome
___ Chrons
___ Colitis
___ Other_____

Fecal Consistency
___ Color feces light or dark _____
___ Normal
___ Soft
___ Hard
___ Pebbles
___ Dry
___ Ribbon-like
___ Bulky
___ Mucous
___ Diarrhea
___ Constipation
Other_____

Cellular Vitality Pillar #7
___ Fatigue constant
___ Dehydrated
___ Slow to Heal
___ Low Stamina
___ Sluggish Memory
___ Inability to achieve lean body

PAIN/ STIFFNESS/ SWELLING/ ACHE/ NUMBNESS/ TINGLING
___ Head
___ Facial
___ Neck
___ Trapezius
___ Upper Back
___ Shoulders
___ Arms
___ Elbows
___ Wrist
___ Hand
___ Mid Back
___ Low Back
___ Sacral Iliac
___ Hips
___ Buttocks
___ Legs
___ Knees
___ Ankles
___ Feet
Other_____

For Doctor's Use
Luna Fingernails Rt 1 2 3 4 5 Lt 1 2 3 4 5
Splinter Hemorrhages
Ear Creases (Rt/ Lt) mild/mod/severe)
Cherry Hemangiomas
Frenular Cyst
Color Tongue_____
Coated Tongue (mild/mod/severe)
Cracks in Tongue-midline/ all over
Swollen Tongue
Dark Veins under Tongue
Allergy Patches Tongue
Red Spots Tongue
Geographic Tongue
Height_____
Weight _____(+/-____lbs) overall(+/-____)
Pulse_____BP:(_____/_____)
saliva pH_____ Urine pH_____
Allergies_____
Current Meds:_____

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I hereby request and consent to the performance of physical examinations, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at Synergy Holistic Health.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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 treatment.

Patient's Name (Please Print)	Signature of Patient/ Legal Guardian
Date	Relationship (if not signed by patient)
Signature of Witness to Above Signature	Date

Nicole Fodel, D.C., MSOM, LAc
Stuart White, D.C.

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

> *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*

A vitamin is not a drug, *NEITHER* is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above:

Patient's Name (Please Print)	Signature of Patient/ Legal Guardian
Date	Relationship (if not signed by patient)
Signature of Witness to Above Signature	Date

Nicole Fodel, D.C., MSOM, LAc
Stuart White, D.C.

Synergy Holistic Health | 2300 B Randolph Rd | Charlotte, NC 28207

OFFICE FINANCIAL POLICY

Our policy is designed to provide you the convenience of allowing you to assign your insurance benefits directly to us. Our policy reduces your out-of-pocket expenses and allows us to place you under our care.

For Chiropractic Care

1. If You Do Not Have Health Insurance: All payments will be due at the time of service/s, or according to the payment schedule based on an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated, unless you have made prior arrangements for a payment plan. Payment plans are available to make treatment an affordable part of your budget.

2. If You Have Health Insurance: All payments will be due at the time of service/s, or according to the payment schedule based on an authorized payment plan. Synergy Holistic Health is not a participating provider with any insurance companies, however you may request documentation to file through your insurance independently. Your personal balance may not exceed $100 at any time or care may be terminated, unless you have made prior arrangements for a payment plan. Payment plans are available to make treatment an affordable part of your budget.

For Nutrition Services: Flexible Spending and Health Savings Accounts

Nutrition services are not covered by any insurance provider; however, you can use a Flex Spending Account (FSA) or Health Savings Account (HSA) to pay for the office visits and supplement purchases. You can also use these accounts for chiropractic services.*** For these types of accounts you may need an itemized receipt or a Letter of Medical Necessity to submit to your insurance company. Our office will provide these upon request.

***__NOTE__: If you use a credit card to pay for any services in our office, we are not permitted to offer refunds to transfer payments to an HSA or FSA account. We can however provide receipts for reimbursement, and for future purchases you may switch to using your HSA or FSA at any time.

Return Policy

Any unopened and unexpired products may be returned for a credit on your account to be used towards future purchases. We do not offer credit card refunds unless you choose to discontinue treatment, in which case a refund may be applied to your credit card.

Cancellation Policy

All appointment cancellations or changes must be requested at least 24 hours before your scheduled appointment time. These changes must be made within our regular operating hours, and therefore cannot be requested on the weekend. For instance, if you have an appointment on a Monday at 9:00am, you must change or cancel the appointment by the Friday before at 9:00am. Any appointment changes with less than a 24 hour notice will result in a $25 cancellation fee.

If you are a "no show" for your appointment the same $25 fee applies. If you "no show" a second time then you will not be permitted to reschedule in our office.

Check Sales:

We accept VISA, Mastercard, American Express, and Discover, along with cash and check. There will be a $25 fee for returned checks. We also reserve the right to no longer accept checks from your account if a check is returned.

*Signing below also acknowledges receipt of our *Privacy Notice*, which can also be accessed on www.synergycharlotte.com.

Patient's Name (Please Print)	Signature of Patient/ Legal Guardian
Date	Relationship (if not signed by patient)
Signature of Witness to Above Signature	Date

Synergy Holistic Health
NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice, please contact our Privacy Officer who is Laura Harry

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes recording your current healthcare information in a file so in the future we can see your medical history to help in diagnosis and treatment, or to determine how you are responding to treatment. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. The information disclosed may include information that identifies you and your diagnosis, as well as services rendered, procedures performed, and/or supplies used. For example, if obtaining approval for a hospital stay it may be required that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and licensing.

We may share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Treatment Options: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Appointment Reminders: We may use and disclose information in your medical record to contact you as a reminder that you have an appointment at Synergy Chiropractic & Acupuncture. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual._

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable).

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. A licensed healthcare professional who was not directly involved in the denial of your request will conduct the review. We will comply with the outcome of the review. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. A written request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of

that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means that if you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You may make a request in writing for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. A written request is required and must state a time period which may not be longer than six years. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to receive a notice of a breach. We are required by law to notify you of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no longer than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

If you believe your privacy rights have been violated by us you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Laura Harry** at **(980) 355-0842** for further information about the complaint process.

This notice was published and becomes effective on **November 22, 2010.**