WELCOME TO THE WELLNESS CENTER OF CHESTER COUNTY, LLC

Patient Information

Name _____
First Name Last Name

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____

Occupation: _____

Is your condition related to:

Employment: Date: _____ Claim? Y / N

Auto Accident: Date: _____ State: _____ Claim? Y / N

Personal Injury: Date: _____ Claim? Y / N

Contact Information

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail: _____

Emergency Contact Info

Name: _____ Relation: _____

Contact Number: _____

Insurance Information

Carrier: _____

Primary on this account: _____

Primary's Date of Birth: _____

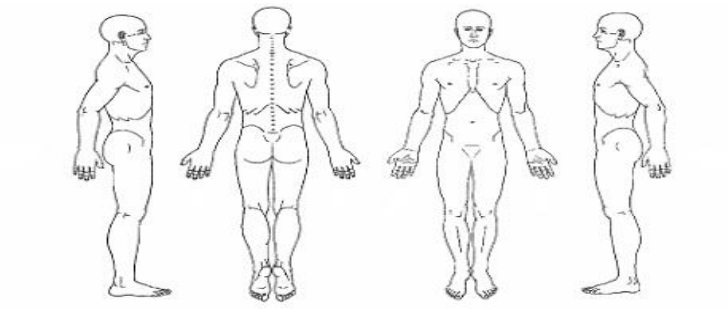
Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named carrier and assign directly to Dr. Joseph Zappy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions and payment plans.

Dr. Joseph Zappy may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my care at The Wellness Center of Chester County has discontinued.

X _____ _____
Signature of Primary Date

Mark the areas of concern on the diagram below:



Average Intensity:
Please Mark an X on the Scale Below

LEAST | _____ | WORST
1 2 3 4 5 6 7 8 9 10

HOW HAVE YOU TRIED TO SOLVE THIS PROBLEM?

☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic ☐ Stretching ☐ Ice ☐ Heat ☐ Massage

WHEN WAS YOUR LAST:

Physical: _____ X-Ray: _____ MRI: _____

PLEASE MARK ALL THAT APPLY:

☐ Allergies
☐ Arthritis
☐ Carpal Tunnel
☐ Constipation
☐ Degeneration
☐ Fatigue
☐ Herniated Discs
☐ Headaches
☐ Kidney Problems
☐ Menstrual Problems
☐ Sinus Pain
☐ Thyroid Problem
☐ Tumors/Growths
☐ Asthma
☐ Bladder Problems
☐ Congestion
☐ Clenching
☐ Digestive Problems
☐ Gallbladder Issues
☐ High Blood Pressure
☐ Irritable Bowel
☐ Liver Problems
☐ Osteoporosis
☐ Stomach Problems
☐ TMJ Pain
☐ Visual Problems
☐ Other: _____

Medications: _____

_____

_____

Allergies: _____

_____

Stressful Environment? Y / N

☐ Falls: _____
☐ Head Injuries: _____
☐ Broken Bones: _____
☐ Dislocations: _____
☐ Surgeries: _____
☐ Other: _____

HIPAA ACKNOWLEDGEMENT FORM:
Notice of Privacy Practices
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been provided:

The Wellness Center of Chester County, LLC's (WCCC) Notice of Private Practices (NPP).

- It tells me how WCCC will use my health information for the purposes of treatment, payment of treatment, and WCCC's health care operations
- NPP explains in detail how the WCCC may use and share my health information for other than treatment, payment, and health care options
- WCCC will also use and share my health information as only required and/or permitted by law
- I consent to the WCCC using and disclosing my treatment for the purposes detailed in the NPP.

X _____

Patient/Guardian Signature Date

INFORMED CONSENT:
Please Read Carefully

I understand that there are beneficial effects associated with these treatments procedures including decreased intensity of pain, improved mobility, improved function, reduced frequency of occurrence in symptomatology, and lower duration of experienced symptoms. I also understand that my condition may worsen and referral may be necessary if a course of Chiropractic care does not help or improve my condition.

Reasonable alternatives to the procedures provided at this office have been explained to me including prescription medications, over-the-counter medications, surgical options, and non-treatment. Risk of these alternatives have also been explained to me. I have read the previous information regarding risks of Chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to these options. All of my questions have been adequately answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

X _____

PATIENT [or PARENT/GUARDIAN] SIGNATURE DATE

_____

DOCTOR SIGNATURE DATE

DOCTOR'S EXAM NOTES

THE WELLNESS CENTER OF CHESTER COUNTY, LLC
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