Comprehensive Chiropractic & Rehab™

Name: _____ **Date of birth**: _____/_____/_____ **SSN**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell**: _____ **Email**: _____

Gender: ☐ Male ☐ Female **Work Status:** ☐ Full ☐ Part ☐ Unemployed ☐ Retired **Student Status**: ☐ Full ☐ Part

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partnership ☐ Widowed

OPTIONAL: Preferred Language:_____ ☐ Decline ☐ Blank

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White ☐ Decline ☐ Blank

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline ☐ Blank

Current Primary Care Physician/Practice: _____

Medical History/Conditions (Check all that apply):

☐ Anemia	☐ Arthritis	☐ Asthma	☐ Atherosclerosis	☐ Bruises Easily
☐ Cancer _____	☐ Cholesterol	☐ COPD/Bronchitis	☐ DVT/Blood Clots	☐ Diabetes
☐ Epilepsy/Seizures	☐ Frequent Colds or Flu	☐ Fracture**	☐ Fibromyalgia	☐ Gallstones
☐ Heart Disease	☐ Hypertension	☐ Headaches/Migraines	☐ Hepatitis	☐ Insomnia
☐ Jaundice	☐ Kidney Disease	☐ Kidney Stones	☐ Liver Disease	☐ Meningitis
☐ Mental Health Issues*	☐ Mononucleosis	☐ Obesity	☐ Open Sores/Wounds	☐ Pneumonia
☐ Pulmonary Disease	☐ Rheumatoid Arthritis	☐ Shortness of Breath	☐ Sprains/Strains**	☐ Stroke
☐ Skin Rashes	☐ Skin Conditions	☐ Thyroid Disorders	☐ TMJ	☐ COVID

☐ Diagnosed with an auto immune disorder not listed:_____

*Mental Health Issues: _____

**Fractures, Sprains, Strains: _____

Are you currently pregnant? ☐ Yes ☐ No If yes, how far along are you? _____ Trimester _____ # of weeks

Name of OB/GYN Practice: _____ Last Visit: _____

Surgical History (Check all that apply):

☐ Appendectomy	☐ Cardiovascular procedure	☐ Hysterectomy	☐ Gall Bladder Removal
☐ Carpel Tunnel Release	☐ Hernia Repair	☐ Joint Replacement(s):_____	
☐ Other Gastro-Intestinal procedures		☐ Bariatric Surgery, type_____	

☐ Spinal procedures: ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Cosmetic/Plastic Surgery: _____

Allergies (Check all that apply):

☐ Eggs	☐ Fish and Shellfish	☐Milk or Lactose	☐ Peanuts	☐ Nuts: _____
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Others:_____	

Current Medications

_____ _____ _____

_____ _____ _____

Radiology Testing: Spinal x-rays or MRIs recently? ☐ Yes ☐ No When_____ Where _____
Previous Chiropractic Treatment? ☐ Yes ☐ No When_____ Where _____
Do you wear any of the following? Heal Lifts: ☐ Yes ☐ No Arch Supports: ☐ Yes ☐ No Prescription Orthotics: ☐ Yes ☐ No

Have you had or been involved in a recent injury? ☐ Yes ☐ No
Was it related to: Motor vehicle accident? ☐ Yes ☐ No
If yes, do you have a claim open with your auto insurance? ☐ Yes ☐ No
Personal injury claim? ☐ Yes ☐ No
Workers comp injury? ☐ Yes ☐ No
Date of accident or injury: _____
Did you receive medical attention at an emergency room? ☐ Yes ☐ No If yes, where_____
Do you have an attorney representing your case? ☐ Yes ☐ No
Attorney's Name: _____ Phone: _____
Name of the firm: _____

History of previous injuries or motor vehicle accidents: ☐ Yes ☐ No If yes, please describe injuries below:
_____
_____
_____

Social History (Check all that apply):

☐ Exercise	☐ Yes	☐ No	How many hours per week?_____
☐ Caffeine Use	☐ Yes	☐ No	How many times per week?_____
☐ Drink Alcohol	☐ Yes	☐ No	How many drinks per week?_____
☐ Smoke/Vape	☐ Never	☐ Former	Quit Date: _____
☐ Chew Tabacco	☐ Never	☐ Former	Quit Date: _____

How did you hear about our practice? (Check all that apply):

☐ Internet search	☐ Friend or family referral _____	
☐ Social Media Post/Ad	☐ Drive-By/Walk-In	☐ Health Insurance:_____
☐ Medical Professional or Healthcare provider		☐ Other:_____

What types of services are you interested in? (Check all that apply):

☐ Chiropractic Evaluation	☐ Adjustment	☐ Needleless Acupuncture	☐ Massage Therapy
☐ Cupping Therapy	☐ Personal Training	☐ Nutritional Counseling	☐ Durable Medical Equipment
☐ Custom Orthotics	☐ Laser Therapy	☐ Emsculpt Neo Treatment	☐ Supplemental Products

☐ Other_____

Is there anything you feel that our providers need to know about you? ☐ Yes ☐ No
Please briefly explain: _____
_____

Acknowledgement – by signing below I agree that all the information is accurate and true to the best of my knowledge.

Patient Signature: _____ Date: _____

Legal Guardian's Name (if patient is a minor): _____ Date: _____

Legal Guardian's Signature: _____

Doctor's Signature: _____ Date: _____

Informed Consent for Treatment

Services: Chiropractic Procedures, Massage Therapy, Laser Therapy, Needleless Acupuncture, Bemer Therapy, Functional Wellness Therapy and Body Contouring/Sculpting using the Emsculpt Neo.

Informed Consent:

I hereby request and consent to the performance of: physical examinations and evaluations and the ordering of any tests or studies required to be performed by an outside provider to diagnose my condition; massage therapy; laser therapy, needleless acupuncture, Bemer therapy, and any esthetic services on myself or on the patient named below, for whom I am legally responsible, by or under the supervision of the chiropractor, or other trained employees listed below and/or other licensed provider(s): who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the provider named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the provider(s) named below and/or with other office or clinic personnel, the nature and purpose of the listed applicable services above and I understand that results are not guaranteed.

I understand and was informed that, as in the practice of all areas of medicine, laser treatment and esthetics, there are some risks to treatment, including, but not limited to, fluid accumulation, tenderness, bruising, dehydration, and death, etc. I do not expect the doctor and/or treating provider(s) and/or with other office or clinic personnel to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor and/or treating provider(s) and/or with other office or clinic personnel to exercise judgment during the course of the procedure which the doctor and/or provider(s) and/or with other office or clinic personnel feels at the time, based upon the facts then known, and is in my best interests.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions if necessary. By signing below, I agree to having any or all the above-mentioned procedures done. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

This practice complies with the rules and regulations set forth by the Pennsylvania Department of Health, including the proper cleaning and sterilization of all tools, products, equipment, and sanitation. The practice of chiropractic care and all other therapy services are regulated by the Pennsylvania State Board of Chiropractic. They can be contacted by telephone at 833-367-2762 if you have any questions, comments, or concerns. The practice of massage therapy is regulated by the Pennsylvania State Board of Massage Therapy. They can be contacted by telephone at 717-783-7155 if you have any questions, comments, or concerns.

Please ask or refer to Comprehensive Chiropractic & Rehab, Inc to review our provider's biographies/credentials.

To be completed by client or/ completed by client's representative or guardian, if client is a minor or is incapacitated.

Client's Printed Name: _____

Client's Signature:_____ Date:_____

Legal Guardian's Signature:_____ Printed Name:_____

Witness's Signature:_____ Date:_____

Comprehensive Chiropractic and Rehab Inc at 1422 Easton Road, Abington, PA 19001-1606
Medical Director/President/Chiropractor: Dr. Wai Wen (Michael) Cheng, DC
Practice Administrator/Certified Chiropractic Clinical Assistant: Jessica Spears, CCCA
Massage Therapist: Janine Chesnes, LMT
Emsculpt Neo Technicians: Stephanie Wang; Jessica Spears, CCCA
Scheduling Coordinator: Pam Spears
Training Coordinator/Office Assistant: Cailtin Cheng

HIPAA Privacy Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting one at the front desk.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

The following person(s) have permission to receive information regarding my records:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ Check is box only if there is no one you are giving permission to.

I,_____have read and fully understand the above statements.

All questions pertaining to my care in this office have been answered to my complete satisfaction. I have read and understand these terms of acceptance and agree to abide by them.

If at any time, I no longer give permission to someone that has been listed above, I will notify the office immediately and sign a new notice of privacy practices.

I therefore accept treatment of service that's provided by Comprehensive Chiropractic & Rehab, Inc.

Client's Signature:_____ Date:_____

Witness' Signature:_____ Date: _____

Office Policy

APPOINTMENTS – In order to obtain the results, we claim and that you desire, it is very important that you keep your appointments as scheduled. We ask that you arrive 5 minutes early for each visit. If you are more than 15 minutes late for a scheduled appointment, you may have to reschedule for another time or day, and optimal results can be compromised. Due to the services that Comprehensive Chiropractic and Rehab provides, time is very valuable. Keep in mind, your appointment time (if missed) could be used to provide service to others. Applicable fees could apply.

CANCELLATION POLICY – We take pride in the appropriate reservation of your appointment dates and scheduled time. Our priority is to scheduled appointments that can be attended to with the utmost of care. Our office scheduling policy is very time sensitive due to the constraints of the different services we offer. Please understand the importance of our Cancellation Policy. All patients are required to give 24-hour notice if cancelling or rescheduling an appointment. All No Shows or cancellations given less than 24-hour notice will be subject to a fee.

PAYMENT FOR SERVICES – Payment in full is required before receiving any service. If purchasing services using a package, the full cost of the package must be paid prior to redeeming services. If you are receiving services that will be billed to your insurance, all deductibles, coinsurance, or copays must be made at the time services are being rendered. If you are financing any services, you must apply for and complete the application process prior to receiving the service. All questions regarding our financing options can be directed to the Practice Administrator. Reference our financial policy for any further details or information.

MEDICAL RECORDS – Comprehensive Chiropractic & Rehab, Inc assures that all medical records are secured within the HIPAA guidelines. Employees of Comprehensive Chiropractic & Rehab, Inc are responsible for safeguarding your record and patient information against loss, altercation, defacement, tampering, or use by any unauthorized person. Under no circumstances will medical records leave the premises without written permission from the patient to be released or if the records are ordered under a Subpoena or Court Order.

INSURANCE – Comprehensive Chiropractic & Rehab, Inc is participating with most medical insurance companies. For all insurance companies that allow for chiropractic procedures as a covered benefit on the specified health insurance plan, we will submit claims directly to the health plan for payment. We also accept most auto insurance plans providing that they offer medical benefits as part of the coverage following an automobile accident. We do accept many different personal injury claim insurance policies as well as workers compensation plans if you are injured on the job. It is best to consult with your adjuster or point of contact with both types of injuries to make sure they do not require you to be referred to chiropractic care by a specific provider that is on preferred list for that insurance type.

PATIENT'S RIGHTS – All patients are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy if known. A patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Registration in the Department of Regulatory Agencies.

DISMISSAL OF CARE – We are committed to providing each client/patient with the highest quality of care while extending the utmost respect for each individual and their needs. In return, we also ask that our clients and their loved ones extend the same courtesy to our staff and providers clients who demonstrate non-compliant, rude or disruptive behavior may be dismissed from our practice . Non-Compliance with any of the above is a reason for dismissal of care. We want you to be as successful in reaching your goals as we are in providing the most professional and the highest quality of care.

I, _____, have read and fully understand the above statements. All questions pertaining to my care in this office have been answered to my complete satisfaction. I have read and understand these terms of acceptance and agree to abide by them. I therefore accept the treatment of the service that is provided by Comprehensive Chiropractic & Rehab, Inc on this basis.

Client's Signature:_____ Date:_____

Witness' Signature:_____ Date:_____

Financial Policy

Please review and initial next to each of the following to acknowledge that you understand and accept each of the listed policies by Comprehensive Chiropractic & Rehab, Inc.

PAYMENT DUE TIME OF SERVICE: We accept cash, checks, all major credit or debit cards, ApplePay, and PatientFi financing. Once payment, or a portion of payment, has been received for services, there will be no monies returned, under any circumstances.

*Please Note: All treatments expire **1 year** from the original purchase date.* Initials_____

RETURNED CHECKS: $50.00 fee added to all returned checks to cover the fees we would incur with our bank.

Initials_____

DELINQUENT ACCOUNTS: In the event an account becomes over **90 days** delinquent, I understand that Comprehensive Chiropractic & Rehab, Inc is entitled to send my account to an outside collection agency. If this action is necessary, I understand and agree that I will be responsible for all additional costs of collecting monies owed, including court costs, collection agency and attorney fees, plus any interest, if applicable on all such balances.

Initials_____

TREATMENT REFUND: There is a non-refundable $100 Administrative Processing fee associated with any refund for the Emsculpt Neo treatments. Administrative Processing fee covers support staff time and appointment time blocked. Administrative Processing fee will be waived if participant reschedules treatment. All refunds will be issued for the unused treatments only. Please allow 7-10 business days for your refund request to be processed.

Initials_____

PRODUCT REFUND: Due to personal hygiene and health and safety policies we cannot give refunds on any products that's been opened. Unopened products will be granted a full refund, less than 15% restocking fee. The re-stocking fee equivalent to 15% percent of the purchase price of the specific product.

Initials_____

NO SHOWS/ LATE CANCELLATION: No shows and late cancellations without 24 hours' notice will be subject to charge of **$50** for all services except for the Emsculpt Neo treatments, a $100 fee will apply.

Initials_____

NON-COVERED SERVICES: Laser Treatment, Bemer Therapy, Emsculpt Neo Treatments, Needleless Acupuncture, unfortunately are not considered a medical necessity and thus not covered by any insurance company. Patients are responsible for payment of treatments 100%.

Initials_____

My signature below indicates that I have read and agree to the terms set above.

I, _____ have read and fully understand the above statements.

All questions pertaining to my care at Comprehensive Chiropractic & Rehab, Inc have been answered to my complete satisfaction. I have read and understand these terms of acceptance and agree to abide by them.

I therefore accept treatment of service that's provided by Comprehensive Chiropractic & Rehab, Inc on this basis.

Client's Signature:_____ Date:_____

Witness's Signature:_____ Date:_____

Comprehensive Chiropractic & Rehab™

MOTOR VEHICLE ACCIDENT QUESTIONAIRE

Name: _____ Date of Accident: _____ Time: _____ AM / PM

Intersection: _____ **City**: _____ **State**: _____

Police/EMT: □ YES □ NO **Police Dept:** _____ **Was a report made?** : □ YES □ NO

Weather conditions: _____

Hospital ER Visit: □ YES □ NO **Where:** _____ **When**: □ IMMEDIATELY □ NEXT DAY □ _____

Role during the accident: □ DRIVER □ PASSENGER (□ FRONTSEAT □ BACKSEAT) □ PEDESTRAIN

Describe the vehicle you were in: Make: _____ Model: _____ Year: _____

□ Small-sized car □ Mid-sized car □ Large-sized car □ 2-Door vehicle □ 4 Door-vehicle

□ Pick-up truck □ Sports Utility Vehicle □ Mini-van or Cargo Van □ Large truck, bus, semi-truck

What type of vehicle was the car involved? _____

How fast was the vehicle you were in going: _____mph **Other vehicle: _____mph**

At the time of the accident, how were you facing? □ STRAIGH AHEAD □ RIGHT □ LEFT □ DOWN □ UP

Did you wear a seatbelt? □ YES □ NO **Were your brakes applied?** □ YES □ NO **Did the airbags deploy?** □ YES □ NO

Did you brace yourself for the impact? □ YES □ NO

Where was the impact on the car? □ FRONT □ REAR □ LEFT SIDE □ RIGHT SIDE

Were you shoved at the time of impact? □ YES □ NO **If yes**, □ FORWARD □ BACKWARD □ SIDEWAYS

What part of your body hit the interior of the vehicle? _____

What part of the vehicle did your body hit? _____

Is your vehicle totaled? □ YES □ NO **If no, how much damage occurred?** _____

After the accident, where you: □ CONSCIOUS □ UNCONSCIOUS □ DAZED □ CONFUSED

What did you feel or experience at that time? _____

Were you shocked or surprised when the accident occurred? □ Yes □ No

Describe what happened: _____

_____

_____

Have you had treatment since the accident? □ YES □ NO **If yes, with who?** _____

Current Complaints: _____

_____

_____

Rating of your pain when its at the worse: 0 1 2 3 4 5 6 7 8 9 10

Current medications? _____

Allergies? □ YES □ NO **If yes, please list them** _____

Patient's Signature:_____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

Comprehensive Chiropractic & Rehab™

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION/MEDICAL RECORDS

Authorization for Use/Disclosure of Information: I_____voluntarily consent to authorize **Comprehensive Chiropractic & Rehab, Inc (Comprehensive Chiropractic or CCR)** to use and/or disclose my health information and medical records during the term of this Authorization to the practice that I have identified below as the law firm representing a motor vehicle accident case that I was involved in. Date of Loss: _____.

Recipient: *I authorize my medical and health records to be released to:*

Law Firm/Legal Representation: _____

Address: _____

Phone: _____ Fax: _____

Purpose: *I authorize my records to be released to provide documentation of treatment I received, that can potentially be used in a court setting or legal conference regarding the injuries I sustained from the above noted motor vehicle accident.*

Information to be disclosed: *I authorize the release of the following health information: (check all that apply below):*

- ❑ All treatment, therapy and healthcare records pertaining to services received and rendered at Comprehensive Chiropractic as ordered, prescribed, and/or administered by Dr. Wai-Wen (Michael) Cheng, DC and staff representing his practice.
- ❑ These records include treatment status and prognosis, progress notes, reports and testing results ordered by Dr. Wai-Wen Cheng, a list of scheduled and attended appointments, all billing/claims generated and submitted for services rendered and received.
- ❑ All payment details for claims submitted by Comprehensive Chiropractic to _____, known as the automobile insurance company in which I am covered through and provides "Personal Injury Protection" benefits (referred to as PIP coverage) on my policy.
- ❑ All payment details for claims submitted by Comprehensive Chiropractic to _____, known as the health insurance company in which I am covered through and provides medical coverage and health benefits. This policy information was provided as secondary coverage in case the "PIP" benefits and claim coverage exhaust prior to completion of treatment.
- ❑ All out of pocket cost that the health insurance company which my medical policy is through, will be collected at the time of service (this includes co-pays, deductibles and co-insurance); for which is listed as the patient responsibility, are to be included in final billing report(s) from claims processed through the secondary coverage I provided as a backup for billing purposes.

Term: *Until all court related proceedings are completed regarding the case for which representation was retained.*

Redisclosure: *I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.*

Refusal to sign/right to revoke: *I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. I understand I can revoke this Authorization by notifying the office.*

Questions: *Contact Comprehensive Chiropractic & Rehab, Inc at 1422 Easton Road, Attn: Office Manager, Abington PA 19001 or 215-443-5626.*

_____ _____ _____

Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____

Name of Guardian/Representative Legal Relationship Date Witness

Comprehensive Chiropractic & Rehab™

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION/MEDICAL RECORDS

Authorization for Use/Disclosure of Information: I _____voluntarily consent to authorize

(Name of Hospital or Urgent Care Center)

_____

to use or disclose my health information/medical records during the term of this Authorization to the recipient that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient:

Name:_____**COMPREHENSIVE CHIROPRACTIC & REHAB, INC** _____

Address:_**1422 EASTON ROAD, ABINGTON PA 19001**_____ Phone:__**215-443-5626**__ Fax:__**215-443-5973**__

Purpose: I authorize the release of my health information for the following specific purpose: **continuity of care.**

Information to be disclosed: I authorize the release of the following health information: (check one box below)

- ☐ All of my health information that my provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- ☑ Only the following records or types of health information:
  Emergency Department or Urgent Care Center visit records following a MVA on _____, and all radiology reports (including MRI's, X-rays, and CT Scans)

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of _____, 20___.
- ☑ Until the Provider fulfills this request.
- ☐ Until the following event occurs:_____

Rediscloure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at CCR. If I change my mind, I understand that I can revoke this Authorization by providing a written notice of revocation to Comprehensive Chiropractic & Rehab, Inc at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact Comprehensive Chiropractic & Rehab, Inc for answers to my questions about the privacy of my health information at 1422 Easton Road, Attn: Office Manager, Abington PA 19001, or by telephone at 215-443-5626.

✕_____	_____	_____
Signature	Date	Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Witness

REVISED: 6/11/2018 ; 5/18/2023