ABINGTON AESTHETICS & WELLNESS CENTER
AESTHETICS WELLNESS RENEWAL

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: _____

Emergency Contact: _____ Relation: _____ Phone: _____

In the event of an emergency, are we able to release information regarding your treatment or therapy to this contact? ☐ Yes ☐ No

What is the main reason you are here today? _____

_____

Medical History/Conditions – current and past history (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: _____

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: _____

Non-Invasive Cosmetic Procedure History (check all that apply):

☐ Body Contouring or sculpting	☐ Non-Surgical Fat Reduction	☐ Microneedling
☐ Botox	☐ Cellulite Reduction	☐ Coolsculpting
☐ Injectable Fillers	☐ Skin Tightening	☐ Laser Skin Resurfacing

Allergies (Check all that apply):

☐ Eggs ☐ Fish and Shellfish ☐Milk or Lactose ☐ Peanuts ☐ Nuts: _____

☐ Soy ☐ Sulfites ☐ Wheat/Glutens ☐ Others:_____

Current Medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History (Check all that apply):

Exercise ☐ Yes ☐ No Times/week?_____ Smoke/Vape ☐ Never ☐ Former, Quit Date: _____

Caffeine ☐ Yes ☐ No Times/week?_____ Chew Tabacco ☐ Never ☐ Former, Quit Date: _____

Alcohol ☐ Yes ☐ No Times/week?_____

Please check all that apply/Areas of interest:

☐ Aesthetics (skin care)	☐ Emsculpt Neo	☐ Laser Treatments	☐ Pelvic Organ Prolapse
☐ Anti-Ageing	☐ Frequent Urination	☐ Light Therapy	☐ Post-Partum Recovery Support
☐ Body Contouring	☐ Gut Health	☐ Lymphatic Drainage	☐ Sexual Disfunction
☐ Body Sculpting	☐ Hair Regeneration	☐ Medical Weight Loss	☐ Sexual Wellness
☐ Cellulite Reduction	☐ Help with Sleep	☐ Nutritional Supplements	☐ Skin Tightening
☐ Chiropractic Evaluation	☐ Hormone Therapy	☐ Overactive Bladder Support	☐ Vaginal Laxity
☐ Cupping Therapy	☐ Adjustment	☐ Needleless Acupuncture	☐ Massage Therapy
☐ Custom Orthotics	☐ Personal Training	☐ Nutritional Counseling	☐ Durable Medical Equipment

☐ Other _____

For FEMALES ONLY:

Are you currently still getting monthly periods? ☐ Yes ☐ No

If you answered No, how long ago did you stop getting your monthly periods? _____

Have you gone through perimenopause and/or menopause ☐ Yes ☐ No

Are you still experiencing symptoms? ☐ Yes ☐ No

If yes, what are your current symptoms? _____

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

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

Do you have any other medical concerns that are GYN related? ☐ Yes ☐ No

If yes, please describe unless already indicated under the medical history section on page 1. _____

_____

Intimate Health Treatment Questionnaire (check yes or no):

1. Is your sleep interrupted by frequent urination? ☐ Yes ☐ No
   If yes, how often? _____
2. When you sneeze, cough or jump, do you ever leak urine? ☐ Yes ☐ No
3. When you run errands, do you always need to know where the restroom is? ☐ Yes ☐ No
4. Do you wear an adult pad or diaper? ☐ Yes ☐ No
   If yes, how many and how often? _____
5. Do you take medications for incontinence? ☐ Yes ☐ No
6. Do you experience pain with sexual intercourse? ☐ Yes ☐ No
7. Do you experience erectile dysfunction? ☐ Yes ☐ No ☐ N/A
8. Are you satisfied with your overall sex life? ☐ Yes ☐ No ☐ N/A

For CHIROPRACTIC PATIENTS ONLY:

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:

_____

_____

Is there anything you feel that our providers need to know about you? ☐ Yes ☐ No

Please briefly explain: _____

By signing below, you are acknowledging that everything in this document is true and correct to the best of your knowledge.

Client's Signature: _____ Date: _____

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

Legal Guardian's Signature: _____

Clinical Staff's Signature: _____ Date: _____

Informed Consent for Treatment

Services include the following: chiropractic adjustment and other chiropractic modalities, massage therapy, MLS laser therapy, Bemer therapy, needleless acupuncture, non-invasive body contouring and sculpting, skin tightening, cellulite reduction, lymphatic drainage, pelvic floor strengthening to treat urinary incontinence and sexual health and wellness, and aesthetic laser treatments.

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; laser 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 doctor, or other trained/certified 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.

Please ask or refer Abington Aesthetics & Wellness Center, Inc and 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:_____

Abington Aesthetics & Wellness Center, Inc and Comprehensive Chiropractic & Rehab, Inc

CEO, Clinical Director, and Chiropractor: Dr. Wai Wen (Michael) Cheng, DC
COO, Clinical Aesthetics Specialist, and Practice Administrator: Jessica Spears, CCCA
Aesthetics Technician: Stephanie Wang
Massage Therapist: Janine Chesnes, LMT

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 Abington Aesthetics & Wellness Center, Inc and 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 10 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 Abington Aesthetics & Wellness Center (AAWC) and Comprehensive Chiropractic & Rehab (CCR) provide, 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 clients are required to give 24-hour notice if cancelling or rescheduling a chiropractic appointment; 48 hours notice for all aesthetic service appointments. 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 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 at the Practice Administrator. Reference our financial policy for any further details or information.

TECHNICAL DIFFICULTY – AAWC and CCR will not be held responsible on the rare occasion that circumstances out of our control may occur, such as technical difficulties with any device associated with your services. If for any reason this may result in delayed services, and you choose not to continue with said services, any money paid can be used towards other products or services with our center but cannot be refunded. We please ask for your patience if this circumstance may arise and vow to get any issue resolved as quickly as possible. Thank you.

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

INSURANCE – Abington Aesthetics & Wellness Center, Inc is not participating with medical insurance companies. Services provided by Comprehensive Chiropractic and Rehab may or may not be covered by insurance, depending on your specific health plan coverage. This will be addressed individually by the front desk and billing office.

PATIENT'S RIGHTS – All clients are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy if known. A client may seek a second opinion from another healthcare professional or may terminate therapy at any time.

DISMISSAL OF CARE – We are committed to providing each client 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 center. 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 center 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 Abington Aesthetics & Wellness Center, Inc and/or Comprehensive Chiropractic and 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 Abington Aesthetics & Wellness Center, Inc (AAWC) and Comprehensive Chiropractic & Rehab, Inc (CCR).

PAYMENT DUE TIME OF SERVICE: We accept cash, checks, all major credit or debit cards, ApplePay, HSA and FSA account card, & third-party financing via Cherry or Patient Fi. 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 pre-paid expire **1 year** from the original purchase date.*

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

DELINQUENT ACCOUNTS: In the event an account becomes over **90 days** delinquent, I understand that AAWC and CCR 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.

REFUND: ***Notice of Cancellation of Services is required at least 24 hours prior to the start date of treatment. There i a non-refundable $100 Administrative Processing fee associated with any refund. 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 once you have requested it.

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.

NO SHOWS/ LATE CANCELLATION: No shows and late cancellations without 24 hours' notice will be subject to fee. Services provided by AAWC are subject to a $100 no show/late cancellation fee. Services provided by CCR are subject to a $50 fee.

NON-COVERED SERVICES: Aesthetic services offered at our center, unfortunately, are not considered a medical necessity and thus not covered by any insurance company. Patients are responsible for payment of treatments 100%. Some alternative therapies that are provided through chiropractic medicine are not considered a medical necessity and not covered by health insurance. Patients are responsible for payment of treatments 100%. A specific list of these non-covered services is available upon request.

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 Abington Aesthetics & Wellness Center, Inc and 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 Abington Aesthetics & Wellness Center, Inc and Comprehensive Chiropractic & Rehab, Inc, on this basis.

Client's Signature:_____ Date:_____

Witness's Signature:_____ Date:_____