# Fee Schedule

**New Patient:**

| | | |
|---|---|---|
| First Visit: | **Initial Exam and Assessment & Report of Findings**<br>Includes history, consultation, orthopedic & neurological testing, muscle-testing, complete spinal analysis and other necessary exam procedures as needed. Also includes complete report of doctor's findings, diagnosis and treatment schedule with recommendations. (Treatment begins during this session if patient is accepted for care) | $360 |

**Established Patients**

| | |
|---|---|
| Standard office visit (15 min.) | $90 |
| Focused office visit (30 min.) | $180 |
| Extended office visit (60 min.) | $360 |

**Please initial below:**

**_____ I have read and consent to the fee schedule for treatment(s) rendered in this office.**

# MISSED APPOINTMENT POLICY

**Whole Body Health** has made a commitment to timeliness and efficiency.

We do not double-book patients in order to provide you with the most efficient service. Please ensure that you arrive for your appointment on time.

We honor our patients and appreciate mutual courtesy by requesting 48 hour notice of any cancellation or rescheduling of appointments. If an appointment is cancelled or rescheduled in less than a **48 hour window**, a missed appointment charge will be applied (see below).

## ***Mission Statement***

We are dedicated health and wellness professionals striving to educate, empower, serve, and support you, in a joy-filled and caring atmosphere utilizing the best in applied kinesiology and chiropractic care.

## MISSED APPOINTMENT CHARGE:

10 min. office visit: $30
15 min. office visit: $50
30 min. office visit: $90
60 min. office visit: $180

Asyra appointment: $75
Oligoscan Appointment: $75

I have read and understand this policy, and I agree to comply.

Signature _____ Date _____

# INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical and manual therapy on me (or on the patient named below, for who I am legally responsible) by Carl Amodio, D.C.

I have had the opportunity to discuss with Dr. Amodio and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I acknowledge that Dr. Carl Amodio is not a medical doctor. I understand that Dr. Amodio provides nutritional and other health-related information to help me attain and maintain my best health. Dr. Amodio will help determine which nutrients my body may need to increase my health. All recommendations are designed to help me keep and enjoy my best state of health through personal recommendations of lifestyle, exercise, health habits, and advanced nutrition. I understand that Dr. Amodio does NOT diagnose, treat, cure, or claim to cure cancer or any other disease.

I also understand and I 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, sprains, strains, ligamentous injuries, tendon injuries, muscle injuries, etc. I do not expect the doctor to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise his judgment during the course of the procedure which he feels is (based on facts known to him) 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 mentioned procedures. I intend for 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: _____Signature:_____Date:_____**

**Representative signature: _____Relationship:_____Date:_____**

# CONFIDENTIAL PATIENT HEALTH RECORD

*Dear patient: this information is considered confidential. We need this information because your answers will help us to determine if chiropractic care can help you. If we do not sincerely believe that your condition will respond satisfactorily to chiropractic care, we will not accept your case. In order for us to understand your condition properly, please be as accurate as possible in completing this form. Thank you.*

NAME: _____DATE:_____

ADDRESS: _____

CITY: _____STATE:_____ZIP CODE: _____

E-MAIL:_____

PHONE :( H) _____ (CELL) _____ (W) _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

HEIGHT: _____WEIGHT:_____MARITAL STATUS: _____

CHILDREN NAMES & AGES_____

OCCUPATION: _____EMPLOYER:_____

PATIENTS NEAREST RELATIVE:_____PHONE:_____

PERSON TO CONTACT IN EMERGENCY: _____PHONE:_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

## INFORMATION PERTAINING TO PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME & PHONE# (IF DIFFERENT FROM ABOVE): _____

ADDRESS: _____

DO YOU HAVE MEDICARE OR MEDICAID HEALTH INSURANCE? YES NO

**NOTE: Whole Body Health, Inc. does not file insurance. You must request a "Super Bill" and file directly with your insurance company for reimbursement.**

**Please rate on the scale how serious you are about getting well. (Please circle number)**
**1 2 3 4 5 6 7 8 9 10**
**(1 being not serious and 10 being very serious)**

**Would you prefer: (Please circle)**
**A. Temporary Symptom Relief**
**B. Correction of Cause of Health Problems**

**Are you willing to follow a treatment program designed to help you return to optimum health? (treating the cause) YES NO**

**Are you willing to take supplements if needed?**
**YES NO**

**Are you willing to make dietary changes if needed?**
**YES NO**

**How serious are you about staying healthy after your initial care?**
**1 2 3 4 5 6 7 8 9 10**

**Are you familiar with Applied Kinesiology and/or Reflex Analysis?**
**YES NO**

**Please rate your stress level on the scale.**
**1 2 3 4 5 6 7 8 9 10**

I understand and agree that payment is due and payable at the time that services are rendered. Furthermore, I understand that payment for any remedy that is shipped to me at my request is to be paid for at the time of my visit. I also understand that the doctor's office will prepare any necessary reports and forms to assist me in making collections from my insurance carrier upon my request. I do understand and agree that the doctor's office will not, and is under no obligation to fill out or file any insurance claims for me, nor await payment for said claims. I clearly understand that any health or accident insurance policies, or disputes, are between the insurance carrier and myself, and that I am responsible for the full balance incurred by me.

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

**X**_____

**Guardian or Spouse's Signature Authorizing Care:** **Date:**

**X**_____

Please fill out all the information below as completely as possible. It is essential that this office has all the information about your medical history available so that an accurate diagnosis may be made.

| Doctor(s) Name | Phone Number | Address |
|---|---|---|
| 1. | | |
| 2. | | |

| Current Medications | Medication Allergies |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

| Food Allergies | Other Allergies |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

| Previous Illnesses | | Previous Surgeries | |
|---|---|---|---|
| 1. | Date: | 1. | Date: |
| 2. | Date: | 2. | Date: |
| 3. | Date: | 3. | Date: |
| 4. | Date: | 4. | Date: |
| 5. | Date: | 5. | Date: |
| 6. | Date: | 6. | Date: |

What Is Your Chief Complaint?

Date When Chief Complaint Began: / /

What Caused It?

Is The Pain Constant Or Intermittent?

DESCRIBE THE QUALITY OF PAIN: Mark all that apply:

Sharp ( ) Dull ( ) Stabbing ( ) Aching ( ) Tingling ( ) Burning ( ) Numbing ( ) Radiating ( )

Is The Pain Getting Worse? Y / N

Does anything make it better? Y / N

What?

Does Anything Make It Worse? Y / N

What?

DOES IT INTERFERE WITH? (Mark All That Apply)

Work ( ) Daily Routine ( ) Sleep ( ) Other? ( )

Explain:

Have you ever had this pain before? Y / N When? What did you do?

Was this effective? Y / N

Have you had any accidents? Y/N

IS YOUR MAJOR COMPLAINT THE RESULT OF ANY TYPE OF ACCIDENT? Y/N Date of Accident / /

If so what? Work ( ) Home ( ) Automobile ( } Other ( )

Are you now disabled from work? Y / N How long? _____

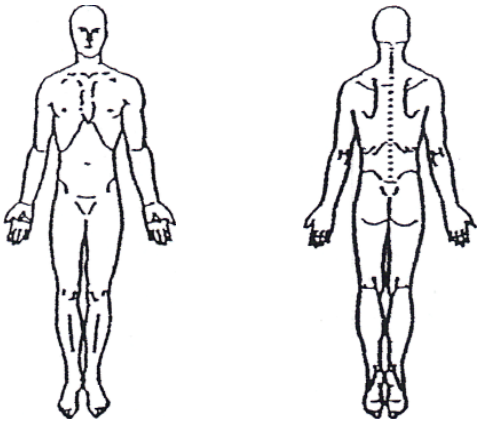
Explain:

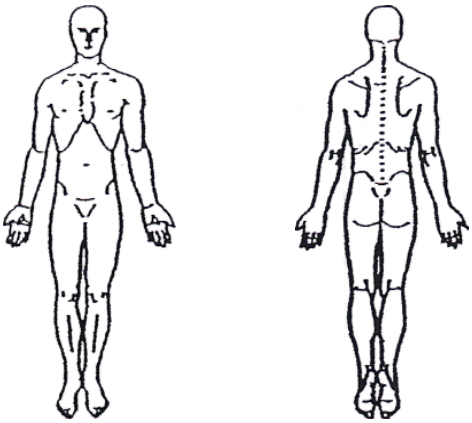
# HISTORY OF INJURIES

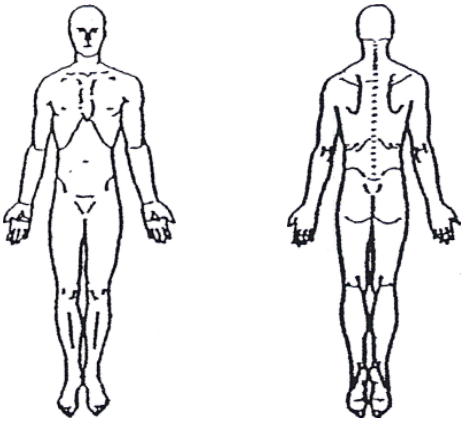
**NAME**_____**DATE**_____

**PLEASE MARK ALL PLACES THAT HAVE EVER BEEN INJURED**

(Sprains/Strains, Broken Bones, Severe Bruises, Surgery, Scars, Head Bumps, Cuts, Burns, Etc.)







| What happened? | When did it happen? |
|---|---|
| | |

| What happened? | When did it happen? |
|---|---|
| | |

| What happened? | When did it happen? |
|---|---|
| | |

# PATIENT AND FAMILY MEDICAL HISTORY

| Conditions | History* (see bottom) | Presently or How Long Ago |
|---|---|---|
| Anemia | | |
| Arthritis | | |
| Asthma | | |
| Back Pain | | |
| Bladder Trouble | | |
| Cancer | | |
| Chest Pain | | |
| Diabetes | | |
| Epilepsy | | |
| Fatigue | | |
| Headaches | | |
| Heart Condition | | |
| Hepatitis | | |
| High Blood Pressure | | |
| HIV/AIDS | | |
| Hypo/Hyper Glycemia | | |
| Indigestion | | |
| Kidney Disorder | | |
| Lung | | |
| Mental Illness | | |
| Menstrual Cramps | | |
| MS/Lupus | | |
| Neck Pain | | |
| Numbness | | |
| Poor Circulation | | |
| Rheumatism | | |
| Sexual Diseases (STD's) | | |
| Sinus Troubles | | |
| Stroke | | |
| Urinary problems | | |
| Other | | |

*** History:** S-Self M-Mother F-Father GP-Grandparent