Avarta Wellness
3837 E Colonial Drive
Orlando, FL 32803

New Patient Packet

Avarta Wellness

"Embrace your body"

3837 E Colonial Drive ● Orlando, Florida ● 32803 ● 407-228-9599● Fax: 407-228-1922

Date: ______________________ **How did you hear of our Office**____

Mr. Mrs. Ms. Patients Legal Name:____ Nickname:__________________________

Address: ____City:_____________________________State:_____Zip Code:_____________

Home Tel. #:________________________Work or Cell Tel. #:________________________ Email address: ____________________________

Occupation: ___________________Sex: _____ Birth date: _______________ Age: ______ Weight: _____ Height:_______ # of children_______

Marital Status: S M D W Emergency Contact & Number: ____

Insurance: Group Health/ Major Medical : ______________________ Auto______________________ Medicare Medicaid None

If Policy Holder is Different From Patient: (usually spouse or parent of patient)

Policy Holders Full Name: __________________________________ **Birth Date:** _______________ **SS#** ___________________________

Policy Holders Address: __________________________________**City:** ________________________**State:** _____**Zip Code:** ____________

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is strictly confidential)

Please describe why you are here: ____

Please describe your goals in coming to this office: _______________________________________

Traumas

Have you been in an Auto Accident in the last 12 months: ___________________________________

Please list all Auto Accidents you've had: ____

Please list all Major Physical Traumas you've had:____

____

Please describe all surgeries that you've had: ____

Stress

Please describe current level of stress in your life: ____

Please describe any allergies you have: ____

Please list all medications you take (OTC & Prescription): ____________________________________

____

Do you smoke or use recreational drugs: ____

Please describe how often you get sick in a year: ____

Nutrition

Please describe your diet: ____

Please list all supplements you take: ____

Lifestyle

Please describe your exercise in a week: ____

Please describe what you do to relax: ____

Please describe your quantity / quality of sleep: ____

Female Patients: Is there a possibility you are pregnant? YES NO UNSURE

PLEASE CHECK CONDITIONS THAT YOU HAVE EXPERIENCED:

____Numbness/pain: buttocks legs feet or toes **R** **L**
____Numbness/tingling/pain in arms, hands, fingers **R** **L**
____Ear infections
____Ringing in ears **R** **L**
____Dizziness
____Asthma
____High/Low blood pressure
____Menstrual problems/PMS
____Digestive Problems
____Liver / Gall Bladder problems
____Kidney problems
____Arthritis
____Diabetes
____Convulsions/Epilepsy
____Cancer
____Depression
____Stroke
____AIDS/HIV

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Informed Consent

Chiropractic

Chiropractic care seeks to restore health through natural means without the use of medicine, surgery or other invasive means. Chiropractic care is not a substitute for traditional medical care, nor is traditional medical care a substitute for chiropractic.

Diagnosis

Although Chiropractors are experts in the diagnosis of Subluxations, they are not Medical Doctors. As a Chiropractic patient you should be mindful of your own symptoms and should secure other opinions if you have any concerns as to the nature of your total condition. The D.C. may express an opinion as to whether or not you should take this step, and will gladly refer you to the appropriate medical specialist; but you are responsible for the final decision.

Results

You are an individual and your health is unique, therefore it is difficult to predict the time schedule or efficacy of Chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory, response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. The science of Chiropractic and Medicine may never be so exact as to provide definitive answers to every problem.

I, ____, have read and understood this Informed
(print your name here)
Consent, and I hereby consent to chiropractic care from this office.

___________________________________ ___________________________________
Patient Name Patient Signature

_______________________________________ _______________________________________
Print Name of Legal Guardian, if applicable Signature of Legal Guardian, if applicable

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Payment Policies

Payment for your first day's visit is due at the beginning of your office visit.

Please choose the method of payment for today's charges: Cash   Check Credit Card

At the completion of your first office visit, you will be advised as to a time you may return for your second consultation when the Doctor will inform you of your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.

Assignment and Release

I authorize the release of any pertinent information necessary for me to receive treatment and for provider to timely process my insurance claims. I authorize my insurance benefits to be billed by and paid directly to:

Avarta Wellness
John W. Staub, DC
3837 E Colonial Drive
Orlando, FL 32803
407-228-9599 (Office)   407-228-1922 (Fax)

I acknowledge that I am financially responsible for non-covered services. I agree that I will be responsible for all attorneys and legal fees if legal action becomes necessary to collect these fees.

Date ______________________   Patient's Name ______________________

Patient's Signature ______________________

Print Name of Legal Guardian, if applicable ______________________   Signature of Legal Guardian, if applicable ______________________

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Avarta Wellness
Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Avarta Wellness to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). With this consent, Avarta Wellness may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my care

With this consent, Avarta Wellness may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Avarta Wellness may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Avarta Wellness restrict how it uses or discloses my PHI to carry out TPO.

With this consent, Avarta Wellness may post my picture and testimonial on the bulletin board located in the office.

By signing this form, I am consenting to allow Avarta Wellness to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Avarta Wellness may decline to provide treatment to me.

________________________ Dated

_______________________________________ Patient's Name

_____________________________________ Patient's Signature

____ Print Name of Legal Guardian, if applicable

____ Signature of Legal Guardian, if applicable