Aloha Wellness

12915 Jones-Maltsberger Road, Suite 604, San Antonio, Texas 78247

Thank you for choosing Aloha Wellness for your chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy life. We will be working together to help you and your family reach your health and wellness goals. We are committed to the success of your care.

There are numerous ways in which you may benefit from Chiropractic Care and how you benefit is always up to **You.** In order to serve you better please indicate which of the following services you are interested in receiving.

Types of care you interested in:

Please check all that may apply.	Yes	Not sure (But like to learn more)	No
Acute Care - Temporary relief of symptoms.	☐	☐	☐
Corrective Care - Correct the problem.	☐	☐	☐
Developmental/Wellness Care - Correct the problem, help prevent recurrences & achieve maximum health benefits for a more active, youthful adult life & provide excellent stress relief & boost immunity.	☐	☐	☐
Family & Pediatric Wellness Care - Safe & effective care that can reduce your family's needs for unnecessary and/or ineffective medication and/or surgery. Achieve maximum benefits through natural health care to ensure a more active family relationship with less stress.	☐	☐	☐

Types of additional wellness services:

☐	Specific Nutritional Healing	☐	Cleanse/Detoxification/Purification
☐	Safe Homeopathic Products	☐	Rehabilitation/Exercise
☐	Weight Management	☐	Foot Orthotics/Traction Pillows
☐	Allergy/Sensitivities	☐	Health Talks/Wellness Workshops

Thank you for taking the time to complete our client wish list allowing us to provide the best possible care and services to meet your specific needs and desires. We look forward to a long, healthy relationship with you and your family.

Financial Policies

Each visit may consists of a combination of examination, consultation, problem-solving, and several different types of procedures. We are combining skills that draw from many disciplines such as modern chiropractic, mind-body healing, physiologic balancing, exercise instruction, specific nutritional healing, and other various modalities. Each visit procedures may be limited by plan selection.

Summary of Fees (vary by level of service and plan choice)

Initial Visit (Consult/Exam/Spinal Adjustment, 30-45 minutes)..... $125.00, 200.00
Second Visit (Report of findings/Care plan, Adjustments, 10-15 min)..... $93.00, 138.00
Regular Visit (Adjustments/Care not including modalities, 3-10 minutes)..... $75.00, 95.00
Re-exam (Exam, not including scans, x-rays, adjustments)..... $23.00, 43.00, 60.00
12 or 8 Visit Plan (1 re-exam, ~$55 per visit, Save 43%)..... $650.00/$450.00
Senior Plan 12 Visit Plan (1 re-exam, ~$45 per visit, Save 67%) $550.00

Choose the plan below best suited to you. Please notify us if there is a need to change plans.

Plan 0-	Pay as you go. File insurance. No savings in time, or visit commitment.	Self-Pay/Medicare/Auto & Health Insurance Benefits: No upfront commitment.	Full Price per Service Time of Service Discount
Plan 1-	12 or 8 visits Prepaid More than 50% Savings.	Self-Pay/Medicare/High Deduct Insurance Benefits: Commitment savings.	Prepay (12 or 8 Visit) Includes Time of Service Discount

All nutritional supplements, homeopathic, botanicals, Isagenix, and miscellaneous therapeutic supplies are charged separately. Examinations, scans and additional procedures may carry extra charges. Any additional insurance forms, reports, or requests for information may be completed by our office for an additional charge, which may not be covered by your insurance carrier.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office may prepare any necessary reports and forms to assist in collection from the insurance company and that amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt without refund. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. Payment may be in the form of cash, check, money order, or credit card.

I have read and understand the above financial policies. I understand that I am responsible for all bills incurred at this office.

_____ Print Name

_____ Signature

_____ Date

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Please print clearly and fill in completely

Print Name _____ SSN# _____-_____-_____
Street Address _____
City _____State _____ Zip Code _____ Date of Birth_____
Phone: Home:_____Work:_____ Cell: _____
Email: Primary: _____ Other: _____
Please Circle: Male Female Right-handed Left-handed Single Married Divorced Widowed

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Health History:
Give reason for seeking chiropractic care: _____
_____
Describe any health problems, including how long you've had them:_____
_____
Are you under the care of any other doctor?_____ If yes, the conditions being treated for?
_____
_____
List any current medications: _____
List any past surgeries & dates:_____
List any past accidents & dates: _____
List any x-rays you've had in the past 2 years: _____

Personal & Family History:
Your Occupation:_____ Work Duties:_____
Employer/Address: _____
Spouse's Health status:_____
Children's age and health status:_____
Chiropractic History:
Have you ever been to a chiropractor before? _____ If yes, Doctor's Name:_____
Date of last chiropractic visit:_____ Reason for care:_____
Date of last chiropractic X-rays:_____ How long were you under care? _____
Are other family members under chiropractic care? _____ Who?_____

Wellness Commitment:
At Aloha Wellness, we are dedicated towards achieving the goal of total lasting wellness for our members. To better help you achieve this, we need to understand your commitment towards being well. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10 to 100%, please circle your personal level of commitment toward obtaining and maintaining your health and wellness.

10% --- 20% --- 30% --- 40% --- 50% --- 60% --- 70% --- 80% --- 90% --- 100%

How did you hear about our clinic, or who referred you? _____

Females: Please Check One: Is there a possibility that you may be pregnant? Yes___ No___

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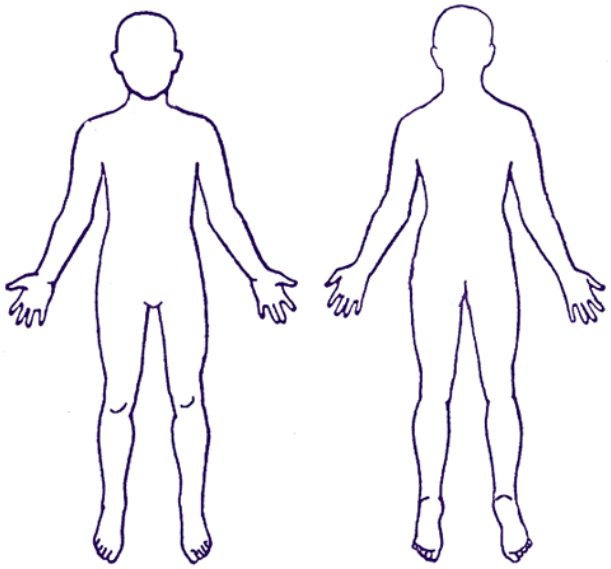
Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check*

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	☐	☐
Migraines	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Arm/hand Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Hip Pain	☐	☐
Leg/foot Pain	☐	☐
Disc Problems	☐	☐
Arthritis	☐	☐
Other Joint Pain	☐	☐
Numbness	☐	☐
Joint Swelling	☐	☐
Dizziness	☐	☐
Nausea	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Insomnia	☐	☐
Heart Problems Vision	☐	☐
Changes	☐	☐
Nose Bleeds	☐	☐
Ringing in Ears	☐	☐
Earaches	☐	☐
Hearing Loss	☐	☐
Cough	☐	☐
Chest Pain	☐	☐
Female Problems	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Diabetes	☐	☐
Hypoglycemia Digestive	☐	☐
problem	☐	☐
Urinary problem	☐	☐
Frequent colds	☐	☐
Skin conditions	☐	☐
Other _____	☐	☐

Circle the areas where you have any problems. Please describe these problems.



Below, please fill in any other health information you feel we might need for your care. _____

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at anytime while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care:

_____ Date: _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working toward the same objective.

Chiropractic has only one goal, health. It is important that each patient understand this objective, the importance of eliminating the subluxation, feeding the body, and their individual role in the attainment and maintenance of their health.

ADJUSTMENT: An adjustment is the specific application of forces used to facilitate the body's correction of nerve interference due to a subluxation. Chiropractors are the only individuals trained and licensed to perform a chiropractic adjustment.

MANIPULATION: The forceful, passive movement of a joint beyond its active limit of motion. It does not imply the use of precision, specificity, or the correction of nerve interference. Therefore, it is not synonymous with a chiropractic adjustment.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease and infirmity! Health is a process where the body accurately perceives its' constantly changing needs and responds appropriately in a timely manner.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebrae in the spinal column, which causes an alteration of nerve function and interference of nerve signals, result inevitably in the decrease of the body's innate ability to express its maximum health potential.

CHIROPRACTIC PRACTICE OBJECTIVE: To correct nerve interference in a safe, effective manner. The correction is not considered to be a specific cure for any particular symptom or disease. It is applicable to any patient who exhibits nerve interference regardless of the presence or absence of disease or symptoms.

We do not offer to diagnose or treat any disease or condition other that the vertebral subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you and refer you to seek appropriate care.

I, _____, have read and fully understand the above statement. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____