Patient Information

Date:	Last Name:	First Name:	Middle Name:	Age:

Address:	City:	State/Zip	Home Phone:
Email Address:			Cell Phone:

Male ( ) Female ( ) Birth Date: Driver's Lic. No.: Single ( ) Married ( ) Divorced ( ) Widowed ( )

Employer Name: Employer Address: Work Phone:

Occupation:

Responsible party if other than patient: Phone Number:

Address: City: State/Zip:

Nearest Friend or Relative not living with you: Address:

Phone Number:

Have you been a patient before? Yes ( ) No ( ) If yes, when?

Referring Physician's Name: Phone Number:

Physician Address: City: State/Zip:

If you were injured, were you injured: On Your Job ( ) Auto Accident ( ) Home ( )

Date of Injury:

Are you off work because of this injury?

Assignment of Benefits

I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to SYNERGY PHYSICAL THERAPY & SPORTS PERFORMANCE rendering services.

X Insured Signature _____ Witness: _____ Date: _____

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Patient Name: _____

OFFICE POLICY

Financial Policy

Thank you for choosing Synergy Physical Therapy as your healthcare provider. We are committed to providing you with a successful course of treatment. Our insurance Department and Office Staff will work very hard to make sure your paperwork is filed accurately and promptly.

In order to provide you with the highest quality service while keeping our billing costs low, we offer paperless billing through QUICK-pay. We simply maintain your credit, debit, or check card on file to satisfy all co-pays, deductibles, and balances not covered by your insurance.

We accept: MasterCard, Visa, Discover, Checks, Cash and Health reimbursement cards.

_____Transfer my balance. **_____Call first, I might want to send a check.**

I authorize Synergy Physical Therapy to maintain my credit card account on file and assign my insurance benefits:

Cardholder Signature:_____Account#_____Exp._____CVV_____

Collection Policy: I understand that any outstanding balance on my account may be referred to an outside collection agency or attorney; If so, a collection fee of 33% will be added to the total balance due at the time my account (s) are referred. Methods of contact may include using prerecorded/artificial voice messages and / or use of an automatic dialing device, as applicable. By signing, I have read this disclosure and agree that Synergy Physical Therapy / collection agency / attorney may contact me as describe above.

Insurance & Insurance collection

Please understand that insurance reimbursement can be a long and difficult process. In fact, insurance companies will routinely stall, deny, reduce payments, or say they never received a claim from our office. Please be assured that we will bill your insurance company every Friday.

Synergy Physical Therapy will not enter into any dispute with an insurance carrier. A dispute over payment of claims is the responsibility of the patient. In the event your insurance carrier does not pay in a timely manner (60-days) it is ultimately, your responsibility to see that the payment was made. Please initial next to your category of insurance listed below, as this will help us to speed up payment and eliminate any confusion in the future. Thank you.

_____**PPO and HMO PLANS.** We have agreed to accept the discounted rate from your plan, however all co-insurance is your responsibility. We will estimate balances to the best of our ability. Since the balances are estimates only, we recommend QUICK-pay. After your insurance has cleared, you may leave the balance on you card, or you can send a check.

_____**MEDICARE.** We have agreed to accept the discounted rate from Medicare, however, if you do not have a secondary insurance, the coinsurance (20%) will be your responsibility, as well as your deductible if it has not been met. Also please keep in mind that Medicare has a combined yearly cap on physical therapy, speech, and chiropractic. We will do our best to monitor this limit. Since you may receive services elsewhere you need to keep track as well.

SELF-INSURED PLANS:
These plans are very difficult for us to collect from. This office has been thoroughly trained on how to get reimbursed by your employer, however, in the event there is a problem, you must provide us with the name of your human resources director and/or benefits manager. We may also require your authorization to file a complaint letter to the Department of Labor and your administrator if necessary.

_____If we are not contracted with your administrator of your employer, we may bill your plan as a courtesy. In the event your plan has not reimbursed us within 90 days, we may simply transfer the balance of your account to QUICK-pay.

_____**WORKERS COMPENSATION:** Prior to your first visit we will call your adjuster to obtain authorization for the therapy prescribed by your doctor. We will bill them directly and you will not be responsible for payment. In the event they deny the initial orders or additional physical therapy, we will be unable to treat you. Please keep in mind while you are a patient here you must see your doctor every 30-days for a re-evaluation. It is also your obligation to keep your appointments so that you fulfill the orders prescribed by your doctor.

_____**SECONDARY INSURANCE:** Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

_____**TELEPHONE:** You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you by text messages or emails using any email address you have provided. We have your permission to leave a message regarding your treatment (appointments, insurance information, health care information, etc.).

_____**CANCELLATION POLICY:** If you are unable to keep an appointment, please give our office 24-hour notice, otherwise, you will be charged **$25.00**, which is due on your next visit. We have a confidential answering machine available 24-hours for your convenience.

I have read the above statement of policy, and understand that I am responsible for any and all treatment *that I receive at Synergy Physical Therapy.*

_____ _____
Patient's/Insured's Signature **Date**

_____ _____
Witness **Date**

Medical History

(federal regulations require a medical history to be included in all patients' medical records)

Patient Name: _____ Date: _____

Date of Injury/Surgery: _____ Height: _____ Weight: _____

Reason for Physical Therapy: _____

Have you had previous therapy for your present condition for which you are to receive treatment here?

Yes _____ No _____ If yes, state where/when: _____

Do you now have/or ever had any of the following:

Diabetes	Yes	No	Sensitive Heat/Ice	Yes	No	
High Blood Pressure	Yes	No	Pregnant	Yes	No	Now
Heart Disease	Yes	No	Other Allergies	Yes	No	
Heart Attack	Yes	No	Previous Surgery	Yes	No	
Pacemaker	Yes	No	Hernia	Yes	No	
Headaches (chronic)	Yes	No	Seizures	Yes	No	
Kidney Problems	Yes	No	Metal Implants	Yes	No	
Nervous Disorders	Yes	No	Cancer	Yes	No	
			Other Condition	Yes	No	

If yes on any above, please explain and give approximate dates: _____

_____

Are you presently taking any medication? Yes _____ No _____ if yes, list what medications and for

What condition: _____

_____

The above information is correct to the best of my knowledge.

_____ _____

Patient Signature Date

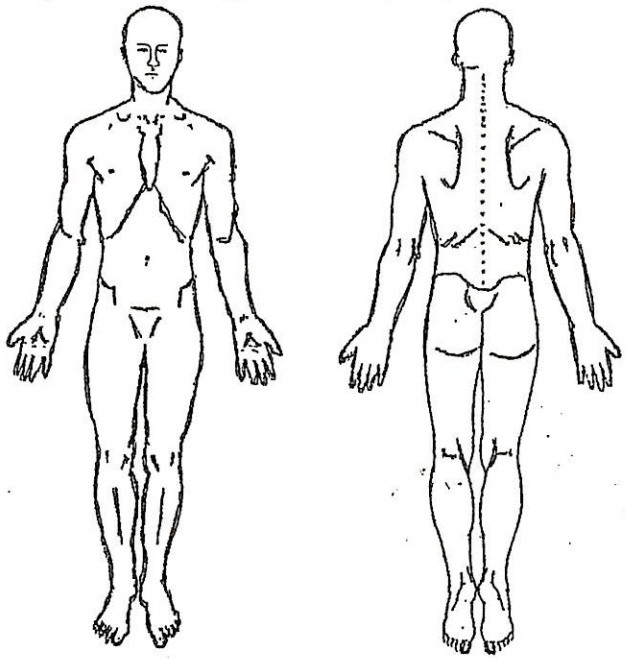
_____ _____

Witness Date

Patient Name: _____

Date: _____

Indicate on the body chart below the location of your injury or condition. If able please write the quality of your injury, condition or pain. (i.e. ache, sharp, weakness, etc.)



On a scale of 0 (no pain) to 10 (unbearable pain), please indicate the range of your discomfort: 0 — 5 — 10 **No Pain** **Unbearable**
How did injury occur:
Headaches: Yes No *Night pain/Disturbed Sleep: Yes No*
Symptoms are aggravated by:
Symptoms are eased by:
Activities you are currently unable to do because of your injury:
Comments/Goals:

Synergy Physical Therapy and Sports Performance

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text, as amended, is posted in the office and is available upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information, illustrations, and the full complete law, which includes educational videos, are available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provides services or to ensure all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is not the policy of this office to remind patients of their appointments. If, however, we choose to do so, we may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology which you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA and have been offered Business Associate Contracts to execute.

4. You understand and agree to random inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the HIPAA Compliance Officer or the physical therapist. If you do not believe your complaints are being heard or acted upon, you may contact HHS.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in a timely manner in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both SPT and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward even though amendments may be enacted.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**