First Name: _____ Last Name_____

Gender_____ Date of Birth_____SS#_____-_____-_____

Address_____City_____State____

Zip Code_____Phone#_____-_____

Email:_____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

Employer's Name_____Occupation_____

Referring Physician's Name_____

Diagnosis_____

Emergency Contact: _____Relationship:_____

Phone#: ( ) _____-_____

Insurance Information:

Insurance Name_____Policy#_____

Copay: $_____Employer's name:_____

Subscriber's Name: _____ SS#:_____-____-_____

Date of Birth:_____Address: _____

City: _____State: ____ Zip Code: _____

Patient's relationship with the subscriber:_____

The above information is true to the best of my knowledge. I hearby authorize my insurance benefits to be paid directly to Synergy Physical Therapy. I also authorize Synergy physical therapy and my insurance company to release any information required to process the claims.

Patient's Signature:_____Date:_____

Consent to Physical Therapy Evaluation and Treatment: I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Synergy Physical Therapy. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risks that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds: I authorize payment of medical benefits to Synergy Physical Therapy. for services rendered. Synergy Physical Therapy. will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

Payment Options: We accept personal checks, cash, VISA and MasterCard. Insurance co- payments are due at the time of service. If we have to bill your co-pay, a service fee may be applied to your bill. **Any portion of your treatment that is not covered by your insurance becomes your responsibility and is due within 30 days**. Interest may be charged at a rate of 1% each month (12%) annually) for unpaid balances over 30 days old. A $25 fee will be charged for all checks returned as insufficient funds.

Patient Information Consent Form (HIPAA): I have read and fully understand Synergy Physical Therapy Notice of Information Practices. I understand that Synergy Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Synergy Physical Therapy will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Synergy Physical Therapy Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Synergy Physical Therapy has 30 days to respond to my request.

Release of Information: I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Designated Individuals Authorization

I, _____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print “none” below.

Authorized Designees

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above.

Patient Signature _____ Date_____

LATE CANCEL / NO SHOW POLICY

Please call our office if you cannot come to an appointment already scheduled. If you do not call at least 24 hours (during business hours) prior to your appointment time, there will be a **$120 late cancellation fee.** Failure to call or show for an appointment will result in a **$120 No Show fee**.

Patient Signature _____ Date_____