PATIENT INFORMATION

******Please present your insurance card(s) for copying.******

Patient Name:	**Date of Birth:**	**Age:**	**Sex:** M F
Social Security Number: _____ –____ –_____	**Employment Status:** Emp Unemp Retired Student Home/Self	**Marital Status:** Single Married Other	
Address:	**City, State, Zip**		
Home Phone: OK to leave message? Yes No	**Cell Phone:** OK to leave message? Yes No	**Email:**	
		Employer:	
Referring MD:	**Primary Care MD:**		
Subscriber:(if other than patient)	**Relationship:**	**Social Security Number:**	**Date of Birth:**
Home Phone:	**Work Phone:**	**Employer:**	
Emergency Contact:	**Relationship:**	**Home Phone:**	
Address:		**Work Phone:**	

CANCELLATION POLICY and CONSENT TO TREAT

At Synergy Physical Therapy we want to provide the best possible care for our patients and attending your scheduled appointments is a necessary part of the treatment process. **A $50 no-show fee will be billed directly to the patient for each cancellation made without at least a 24 hour notice.**
By signing below, you acknowledge that you have read, understood and agree to abide by our cancellation policy as described.

I grant permission for the staff of Synergy Physical Therapy, to perform the procedures as prescribed by my physician including a physical therapy evaluation. During this evaluation, the nature of the procedures that will be performed as well as the potential risks of care will be explained to me.

If I become ill while undergoing treatment, I give permission to the staff to administer treatments which they consider necessary to my well-being. **My signature below indicates that I understand and give consent to be treated as explained above. The information I give is correct to the best of my knowledge.**

Patient Signature:	**Guardian's Signature:** (If patient is <18 years old)	**Date:**

Patient Medical History Form – For Clinic Use ONLY

Name:	Age:	Current Concern/Problem:	**Date of Onset:**

I. Have you ever been diagnosed with any of the following conditions? FILL IN THE APPROPRIATE CIRCLES.

1. Cancer:	Yes	No	Type(s), include date of diagnosis:
	O	O	

2. Infection:	Yes	No	**3. Cardiovascular:**	Yes	No
Chronic Urinary Tract/Kidney Infection	O	O	Heart Disease:	O	O
Pneumonia	O	O	Deep Venous Thrombosis (DVT):	O	O
Bone/Joint Infection	O	O	Arterial Blockage of the Legs	O	O
Viral Conditions:	O	O	High Blood Pressure:	O	O
Other Infection: (Please List)	O	O	Stroke/TIA	O	O
1.			Other:		

4. General Medical Conditions:	Yes	No	**4. General Medical Conditions:**	Yes	No
Rheumatologic Disorders:	O	O	Osteoarthritis: (Wear-and-Tear Arthritis)	O	O
Lung Disorders:	O	O	Osteoporosis/Osteopenia:	O	O
Liver/Kidney Conditions:	O	O	Dizziness or falls:	O	O
Gastrointestinal Disorders:	O	O	Depression:	O	O
Neurological Disorders:	O	O	Bowel/Bladder Incontinence:	O	O
Anemia/Blood Disorders:	O	O	Headaches: (more than 1 per week)	O	O
Thyroid Conditions:	O	O	Vision or hearing difficulty	O	O
Gout:	O	O	Immunologic/Allergy Conditions:	O	O
Diabetes:	O	O	Genitourinary/Gynecologic Conditions	O	O
Dermatologic Conditions:	O	O	Other conditions:		

II. Please List All Medications Including Frequency and Dosage: (both over-the-counter and Prescribed)

	Frequency	Dosage		Frequency	Dosage
1.			4.		
2.			5.		
3.			6.		

III. Surgeries and/or Hospitalizations:		**IV. Other Current Conditions:**	Yes	No
1.	Date:	1. Recent, unplanned weight loss?	O	O
2.	Date:	2. Unexplained night pain?	O	O
3.	Date:	3. Fevers or night sweats?	O	O
4.	Date:	4. Nausea/Vomiting?	O	O
5.	Date:	5. Unexplained weakness or fatigue?	O	O

V. Health-Related Habits

Smoking	Yes	No		Yes	No		
If yes, < 1 pack/day?	O	O	Do you have a Pacemaker?	O	O		
If yes, > 1 pack /day?	O	O	Are you Latex Sensitive?	O	O		
Ice Sensitive?	O	O	**Heat Sensitive?**	O	O		
Previous experience with physical therapy?	O	O	**How many falls have you had in the last year? _____**			**Are you currently pregnant?_____**	

I affirm that the above information is accurate and true.

Patient Signature_____ **Date**_____ **Therapist Review (Initials)** _____

FINANCIAL POLICY

This is the financial policy of Synergy Physical Therapy. This is an agreement between Synergy Physical Therapy and the Patient/Responsible Party signed on this form. **By executing this agreement, you are responsible for all medical bills and other charges that result from services rendered by Synergy Physical Therapy.**
Regardless of insurance coverage you are responsible for all balances incurred. Some insurance companies may pay fixed allowances for certain procedures, sometimes referring to these as "Reasonable and Customary Fees." We do not accept this as payment in full, unless otherwise restricted by law or contract agreement we may have with your insurance carrier(s). Many insurance companies pay only a percentage of the charge, leaving it your responsibility to pay any deductible amount, co-insurance amount, co-pays (due at each visit) and any other balance not covered by your insurance carrier(s). As a courtesy, our office may inform you of the benefits we were quoted by your insurance carrier(s). However, this is not a guarantee of your actual benefit plan or payment. If you have any further questions, please contact your insurance carrier(s).

ASSIGNMENT OF BENEFITS: I hereby assign all medical/physical-occupational therapy benefits, to which I am entitled, Medicare, private insurance and other health plans to: Synergy Physical Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize Synergy Physical Therapy to release all information necessary to secure the payment, via fax transmittal or hard copy. Medical records will be accessible to all physical therapists of Synergy Physical Therapy.

INJURIES AT WORK: In the event it is determined by your Industrial/Worker's Compensation insurance that the illness/injury is not a result of a compensated Workman's Compensation case, you will be responsible to pay usual and customary fees for services rendered. If you do not have your information at this time, please get it to us within 48 hours.

AUTO ACCIDENTS: Auto insurance claims will be billed to YOUR auto carrier, not to any other parties' auto carrier due to Utah's No Fault Law. If your auto PIP exhausts, we will bill your health insurance that you have provided. If you do not have your information at this time, please get it to us within 48 hours.

PERSONAL INJURY: If you are dealing with a lawsuit or claim, we require verification from your attorney, as well as a lien agreement that we may keep on file and may require a monthly payment plan. Please remember even if you have an attorney you are ultimately responsible for your bill and ask that you update our office on the status of your case frequently.

PAST DUE ACCOUNTS: An account becomes past due 60 days after it becomes patient responsibility. Your balance will be communicated by statement every month. If your account becomes past due, we will take necessary steps in contacting you to collect this debt. If these attempts do not generate a response from you, your account could be subject to the following fees: Finance Charges (currently 3%), In House Collection Fees, Collection Agency fees and any Attorney fees.

RETURNED CHECKS: There is a fee (currently $25) for any checks returned by the bank.

SELF PAY ACCOUNTS: If you do not have health insurance we do offer self pay plans. Self Pay payments are due at the time of service. Please speak to our Clinical Director for more information. If you are unable to provide us with your health insurance, worker's compensation insurance or personal injury insurance within 48 hours of your first visit you may be turned over to a self pay account status.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable on or before the due date specified on the statement and is past due if not paid on or before that date.

In signing this agreement, I consent to a therapy evaluation and subsequent treatment provided and directly supervised by a licensed physical and/or physical therapy assistant employed by Synergy Physical Therapy, as well as agree to all of the terms and conditions contained herein and the agreement will be in full effect.

Patient Name: _____ Signature: _____

Responsible Party:
(If patient is a minor) _____ Date: _____

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

SYNERGY PHYSICAL THERAPY'S LEGAL DUTY

Synergy Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Synergy Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Synergy Physical Therapy may also use or disclose your personal health information without prior authorization for emergencies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Synergy Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

Attn: David Hunt, Privacy Officer
205 N Main St. Spanish Fork, UT 84660
TEL: 801-436-3110 email privacy@synergy.fit

******Please retain this copy for your records******

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Synergy Physical Therapy's Notice of Patient Information Practices. I understand that Synergy Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Synergy Physical Therapy's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature (Guardian if patient is a minor)

_____

Date