Patient Information Form

Personal Information

Name: ______________________ DOB: __________ SSN: __________

Address: ______________________ City: __________ State: _____ ZIP: ________

Please check the best number to reach you at:

☐ Home Phone: ____________________

☐ Cell Phone: ____________________

☐ Work Phone: ____________________

Email Address

(we will not email anything to you without your knowledge)

____

Are you currently:

☐ employed full time ☐ employed part time ☐ retired ☐ disabled ☐ unemployed

Emergency Contact Information

Name: ____________________ Name: ____________________

Relationship: ____________________ Relationship: ____________________

Phone: ____________________ Phone: ____________________

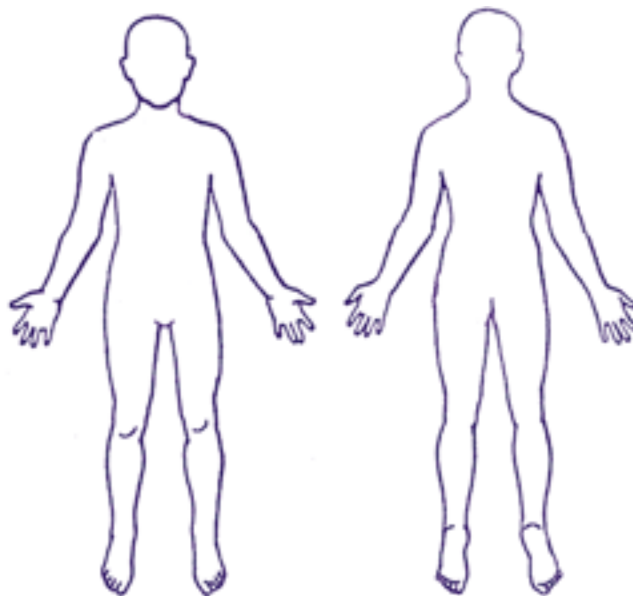
Provider Information

Family Physician: ______________________________

Referring Physician: ______________________________

Indicate your pain on body chart

ppp - Pain ooo - Numbness zzz - Tingling bbb - Burning xxx - Tenderness



Financial Policy
Patient Copy

Thank you for choosing Synergy Physical Therapy and Wellness! We are committed to your entire experience here being successful. As a patient, you have a financial responsibility that obligates you to ensure full payment of your bill. Therefore, all patients are required to establish a financial arrangement for payment of their account. All patients must complete and sign the entire patients registration packet before they receive treatment.

REVIEW YOUR SCHEDULE OF BENEFITS: We STRONGLY urge you to review your insurance policy's "schedule of benefits". It will help you understand the agreement you have with your insurance company. You should verify and understand your policy's deductible, co-payment, co-insurance, visit limitations, and effective annual calendar renewal date, and any pre-authorization requirements. As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. You are responsible to know your level of coverage and your are ultimately responsible for the full payment of your bill.

INSURANCE INFORMATION: We need complete and accurate information about your insurance policy. We will submit claims to your health insurance company for you. You are responsible for payment of any deductible, co-pay and co-insurance as determined by your contract with your insurance provider. You are responsible for any amount or any services not covered by your insurance company.

CHANGES IN COVERAGE: It is your responsibility to inform us of any and all changes to your insurance coverage during the course of your treatment. Failure to do so may result in denial of coverage by your insurance company.

IN-NETWORK: You are responsible for meeting the in-network deductible before your insurance will begin to reimburse for the services rendered. You are responsible for co-payments and/or co-insurance as specified in your "schedule of benefits" after the deductible amount has been paid. Synergy Physical Therapy and Wellness has agreed with your insurance company to accept the Preferred Provider maximum allowable charge as full payment for the services rendered. You are responsible to pay for any services that are received but not covered under your policy. Co-payments and deductible payments are due at the time of service unless otherwise arranged with Synergy Physical Therapy and Wellness. Fee rates are subject to change.

OUT-OF-NETWORK: You are responsible for meeting the out-of-network deductible before your insurance will begin to reimburse for the services rendered. You are responsible for all co-payments and co-insurance payments. You are also responsible for the difference between billed charges and your insurance company's maximum allowable charges. Your out-of-network benefits for outpatient physical therapy will be clearly outlined in your insurance company's "schedule of benefits". We will submit claims for payment to your insurance company. Synergy requires a minimum payment of $30.00 per session after your deductible has been met, which will be applied toward your balance.

NON-INSURANCE-FEE-FOR-SERVICE: Fee-for-service is exclusively a non-insurance financial arrangement. This is exclusively separate from the "in-network" and "out-of-network" payment structures. These service charges cannot be submitted to insurance for reimbursement.

WORKER'S COMPENSATION: If you are claiming worker's compensation, you must provide us with a copy of your personal insurance card and a current authorized C9 form for physical therapy signed by your physician. We will confirm your authorization with your case manager. In the event that payment for your claim is denied by your worker's compensation carrier, you are responsible for the full payment of your bill.

MEDICARE: Synergy is a Medicare-approved provider of outpatient physical therapy. Ohio is a direct access state, which means that you can receive physical therapy services without a physician referral as long as your physician is notified by our office of your treatment plan. Your initial physical therapy plan of care must be certified by your physician, and if your physical therapy extends beyond 30 days after the date of the first certification, the plan of care will need to be re-certified every 60 days by your physician. You may be required to follow-up with your physician more often if therapy is extended to ensure Medicare coverage.

SECONDARY INSURANCE: If you have secondary insurance, you must present it at your initial visit The same policies and responsibilities apply to the use of secondary insurance. You are responsible for the accuracy of the insurance information we use to submit the claim and you are ultimately responsible for the full payment of your bill.

LATE CHARGES/RETURNED CHECKS: Any account that remains open beyond 60 days from the last date of treatment will be subject to a $10.00 late fee for each month that the account is not paid in full. There is a $35.00 late fee for all returned checks.

CANCELLED/MISSED APPOINTMENTS: If you are more than 15 minutes late for your appointment, we reserve the right to reschedule. We require 24 hours notice for cancellations. Appointments that are cancelled with less than 24 hours notice are subject to a $65.00 fee, which is not reimbursable by insurance companies.

DURABLE MEDICAL EQUIPMENT/SUPPLIES: DME and supplies are not reimbursable by insurance companies and must be paid for at the time of your therapy session.

HIPAA Notice of Privacy Practices

Patient Copy

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

Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

- ✦**Treatment** includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, physical therapists and case managers.
- ✦**Payment** includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical records to determine that your care was necessary.
- ✦**Health Care Operations** includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications

You have the right to request confidential communication from us. This request must be in writing.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

This notice is effective September 30, 2008

Patient Authorization Record

Initial here	
	Authorization for Treatment ✦ I hereby give authorization for the performance of such rehabilitation procedures as permitted by the state of Ohio Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ✦ I agree that Synergy Physical Therapy may provide information from my medical record to persons involved in my medical care. ✦ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Synergy Physical Therapy for services rendered. ✦ I agree that Synergy Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ✦ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ✦ I authorize that direct payment of any benefits available to me be released to Synergy Physical Therapy for services rendered.
	Patient Agreement ✦ I agree to pay Synergy Physical Therapy charges for services rendered to me during my course of treatment. ✦ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Synergy Physical Therapy collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ✦ I agree that the information given to Synergy Physical Therapy in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Synergy Physical Therapy may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ✦ I agree that the information given to Synergy Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Synergy Physical Therapy may give intermediary's information necessary to process claims.

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Patient/Legal Guardian/POA signature   Date

Medical History

Patient Name: ______________________ Age: __________

Briefly list the reason you are here today: ______________________

Rate your pain 0-10 ________ (0 is no pain and 10 is emergency room pain)

What activities increase your symptoms? (please check all that apply)

☐ Sitting ☐ Walking ☐ Driving ☐ Kneeling ☐ Twisting ☐ Standing
☐ Reaching ☐ Stairs ☐ Reclining ☐ Lifting ☐ Bending ☐ Squatting
☐ Rising ☐ Other ______________________

What eases your symptoms (please circle)

☐ Moist Heat ☐ Rest ☐ Ice
☐ Change in position ☐ Medication ☐ Other ______________________

Have you recently had any of the following tests? (please check all that apply)

☐ X-Ray ☐ Myelogram ☐ EMG/NCS ☐ Doppler Study
☐ CT Scan ☐ Bone Scan ☐ Blood Test ☐ Pulmonary Functions Test
☐ MRI ☐ Stress Test ☐ EKG ☐ Other ______________________

Do you have or have you had any of the following (please check all that apply)

☐ Diabetes ☐ Bowel/Bladder Problems ☐ Drug Allergies
☐ Chest Pain ☐ Urine Leakage ☐ Allergies to Heat
☐ High Blood Pressure ☐ Asthma/Breathing Problems ☐ Poor Cold Tolerance
☐ Heart Disease ☐ Liver/Gallbladder Problems ☐ Other Allergies
☐ Heart Attack ☐ Hernia ☐ Pacemaker
☐ HeartPalpitations ☐ Seizures ☐ Numbness/Tingling
☐ Metal Implants ☐ Headaches ☐ Skin Abnormalities
☐ Rheumatoid Arthritis ☐ Dizziness/Fainting ☐ Kidney Problems
☐ Recent Fractures ☐ Nausea/Vomiting ☐ Lung Problems/Tuberculosis
☐ Surgeries ☐ Cancer ☐ Osteoarthritis
☐ Osteoporosis ☐ Smoking ☐ Pregnant
☐ Infections/Diseases (ex. HIV, Hepatitis, MRSA) ☐ Neurological Problems
☐ Circulatory/Vascular Problems ☐ Thyroid Problems

Please list any medication(s) you are taking (if you have a list, please allow us to make a copy)

____

____

Do you have difficulty sleeping? ☐ Yes ☐ No

Do you feel unsafe or afraid in your home? ☐ Yes ☐ No

During the past month have you often been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No

______________________ ______________
Patient's Signature Date

______________________ ______________
Therapist's Signature Date