****

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EmployerAddress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is you treatment related to : □ Auto Accident □ Workman's Compensation**

**Auto Insurance Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Auto Insurance Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Auto Insurance Policy Adjuster and Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Worker’s Compensation Company Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Synergy Sports & Orthopedic Physical Therapy, LLC.**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Statement of Patient Financial

Synergy Sports & Orthopedic Physical Therapy, LLC. (Synergy) appreciates the confidence you have shown in choosing us to provide for your rehabilitation needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligated you to ensure payment in full of our fees. As a courtesy, we will verify your primary insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible of any amounts not covered by your insurer. If your insurance carrier denies any part of your claim of if you or your physician elects to continue therapy past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Synergy for providing rehabilitative services to me, or the above named patient or me or, if applicable any amount due after payment has been made by my insurance carrier.

**Patient Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Representative**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(If patient is a minor, or if authorized by patient.)**

# Consent for Treatment and Authorization to Release Information

I hereby authorize Synergy through its appropriate personnel, to perform or have upon the above names patient, or me appropriate assessment and treatment procedures relating to my injury. I further authorize Synergy to release to appropriate agencies, any information acquired in the course of my, or the above names patient’s examination and treatment.

**Patient Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Representative**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(If patient is a minor, or if authorized by patient.)**

# No-Show / Cancellation Policy

We understand that there may be times when you miss your appointment, but request that you give us at least 24- hour notice. Schedule a make-up appointment as soon as possible to help meet your rehabilitation goals.

**Acknowledgement of Receipt of Privacy Notice (HIPAA)**

I acknowledge that I received or was offered the Notice of Privacy Practices for Synergy.

**Patient Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Representative**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Disclosures to Individuals Involved in Patient’s Care (HIPPAA)**

I authorize Synergy to disclose my health information that is directly related to my current treatment to the individuals listed below for purposes of their role in my payment for the health services I have rendered.

Name of Individuals: Relationship to Patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently working? 🞎 Yes 🞎 No Date of next physician’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury/onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had these symptoms before? 🞎 Yes 🞎 No

Check which apply to your current condition:

|  |  |  |
| --- | --- | --- |
| * Work-related injury
* Motor vehicle accident

 🞎 Cause unknown | * Recurrence of previous injury
* Injury related to lifting
* Athletic / recreational injury
 | 🞎 Injury related to falling🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Have you had a related surgery? 🞎 Yes 🞎 No

Do you have, or have you had any of the following?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  |  | **Yes** | **No** |
| Diabetes | 🞎 | 🞎 |  | Allergies to Aspirin | 🞎 | 🞎 |
| Chest pain / Angina | 🞎 | 🞎 |  | Allergies to Heat | 🞎 | 🞎 |
| High Blood Pressure | 🞎 | 🞎 |  | Allergies / Poor tolerance to Cold | 🞎 | 🞎 |
| Heart Disease | 🞎 | 🞎 |  | Other Allergies | 🞎 | 🞎 |
| Heart Attack | 🞎 | 🞎 |  | Hernia | 🞎 | 🞎 |
| Heart Palpitations | 🞎 | 🞎 |  | Seizures | 🞎 | 🞎 |
| Pacemaker | 🞎 | 🞎 |  | Metal implants | 🞎 | 🞎 |
| Headaches | 🞎 | 🞎 |  | Dizziness / Fainting | 🞎 | 🞎 |
| Kidney Problems | 🞎 | 🞎 |  | Recent Fractures | 🞎 | 🞎 |
| Are you pregnant? | 🞎 | 🞎 |  | Surgeries | 🞎 | 🞎 |
| Cancer | 🞎 | 🞎 |  | Skin Abnormalities | 🞎 | 🞎 |
| Osteoporosis | 🞎 | 🞎 |  | Sexual Dysfunction | 🞎 | 🞎 |
| Bowel / Bladder Abnormalities | 🞎 | 🞎 |  | Nausea / Vomiting | 🞎 | 🞎 |
| Urine leakage | 🞎 | 🞎 |  | Ringing in your ears | 🞎 | 🞎 |
| Asthma / Breathing Difficulties | 🞎 | 🞎 |  | Rheumatoid Arthitis | 🞎 | 🞎 |
| Liver / Gallbladder Problems | 🞎 | 🞎 |  | Special Diet Guidelines | 🞎 | 🞎 |
| Smoking | 🞎 | 🞎 |  | Hypoglycemia | 🞎 | 🞎 |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 | 🞎 |  | Stroke / CVA | 🞎 | 🞎 |

## If yes on any of the above, please briefly explain and give approximate dates

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is there any other information regarding your past medical history that we should know about?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List current medications (prescriptions, over the counter, herbals, vitamin/mineral/dietary supplements) including name, dosages, frequency and route.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you participate in any sports, exercise programs or activities on a regular basis? Yes No

**Please indicate on the picture below where your symptoms are located:**



Numeric Pain Rating Scale

1. How would you rate your pain RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

 No Pain Worst Pain Imaginable

1. How would you rate your USUAL level of pain during the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

1. How would you rate your BEST level of pain during the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

1. How would you rate your WORST level of pain during the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Patient’s Signature Date Signature of Guardian if patient is a minor Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature Date