PATIENT INFORMATION

SYNERGY PT, LLC

Patient's Last Name _____ First _____ Initial _____ Date of Birth _____ Marital Status S M D W

Home Phone _____ Work Phone _____ Mobile Phone _____ E-Mail _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Primary Care Physician _____ PCP Phone _____

Referral Source _____ Physician Therapist Friend Family Other

Prior Chiropractic Treatment? YES NO Physical Therapy? YES NO

If YES, what for? _____

INSURANCE PROVIDER _____ **GROUP NUMBER** _____ **MEMBER ID** _____

WORK OR AUTO ACCIDENT INFORMATION (Please complete if applicable)

Is the reason for your visit work or auto accident related? **YES** **NO**

If YES, have you or do you plan to file a worker's compensation or auto claim / legal action? **YES** **NO**

PATIENT SIGNATURE _____ **DATE** _____

AUTHORIZATION FOR MINOR PATIENTS (Please complete if applicable)

I hereby request and authorize Synergy PT, LLC physicians to perform evaluations and diagnostic tests, and render treatments to my MINOR SON / DAUGHTER. This authorization also extends to all other providers and office staff members. As of this date, I have the legal right to select and authorize health care services for the minor child named above. If my authority to select and authorize this care should be revoked or modified in any way, I will notify this office.

NAME OF MINOR PATIENT _____ **DATE OF BIRTH** _____ **NAME OF PARENT / GUARDIAN (**print**)** _____

SIGNATURE OF PARENT / GUARDIAN _____ **DATE** _____ **RELATIONSHIP TO PATIENT** _____

WITNESS _____

We are committed to providing you with the best possible services and would like to make you comfortable in your association with us. The following is a statement of our Financial Policy, which we require you to read and sign. Your cooperation and familiarity with this policy will help to control the costs of your health care.

REGARDING ALL INSURANCE

We cannot promise that an insurance company will pay for your care, even when it is preauthorized. As a courtesy, our office will inquire about your insurance benefits for services / treatments specific to our practice. Please understand that insurance carriers advise us that ***payment of benefits will not be determined until your claim is received and reviewed according to the specifics of your plan***, and that ***a quote of benefits is not a guarantee of payment.*** Understand that you are financially responsible for any co-pays, deductibles, and remaining balances not covered by your plan**.** We strongly urge you to contact the insurance company to verify your benefits, as incorrect information is sometimes provided to us.

We will submit bills to your insurance carrier as soon as we are able to confirm coverage for physical therapy services and have the proper, signed insurance forms, but will not become involved in disputes between the insured and the insurance company.

Payment of non-covered and service balances, co-payments / deductibles is expected at the time of service. **Our office accepts cash, checks, and some credit cards.**

NETWORKS

We are **"in-network"** with **Blue Cross Blue Shield PPO** and **"out-of-network"** with all other insurance plans. As the insured, it is your responsibility to know and understand the benefits of your health insurance plan including differences between in and out of network coverage such as deductible and co-pay amounts, percent of coverage and any referrals that may be required.

Co-payments are **due and will be collected at time of service.**

MEDICARE

Medicare Part B limits the amount of coverage for beneficiaries receiving outpatient therapy services to **$1880** for the **2012 calendar year**, and this includes combined physical and speech therapy. A beneficiary pays the first 20%, then Medicare covers the remaining 80% up to the annual cap of $1880.

Physical therapy services provided to a beneficiary must be under the care of a physician, with a written plan of care, and medically reasonable and necessary. Further information is available at medicareadvocacy.org.

The payment cap per calendar year does not apply to therapy services received in an outpatient hospital setting or emergency rooms.

SUPPLIES / SUPPLEMENTS

All medical supplies or supplements must be paid for at the time of delivery. We **do not** bill your insurance company for these items, but will provide you with the necessary paperwork in order that you may file a claim with your own insurance company for consideration of reimbursement.

WORKERS COMPENSATION & PERSONAL / AUTO INJURY

If the reason for your visit is related to an active or pending worker's compensation or personal / auto injury claim or litigation, you must notify us prior to initiation of care or at any point during care that your case changes to one of these claim types.

Workers Compensation and Personal Injury cases will be seen on a **self-pay basis**, meaning payment for services is due in full at the time of service. We **do not** submit for reimbursement for these cases, nor accept physician's liens, but we will furnish you the information you may need to bill for reimbursement.

COLLECTIONS POLICY

In the event that you do not meet your financial obligation for services provided in our office, we may send your account to a collection agency, typically after 90 days of non-payment. If this becomes necessary, any fees incurred will be your responsibility. You will be notified prior to sending your account to collections. **If you are experiencing financial hardship or there are circumstances which prevent you from paying the full balance due, please contact our office so that we can work with you to find a solution.**

CANCELLATION / NO SHOW POLICY

Patients canceling appointments with less than 24 hours notice or failing to show for a scheduled appointment may be charged a **$30 fee** for that appointment.

NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to this information. A copy of this policy is available from your health care provider.

REQUIRED SIGNATURE

I (signed below) have read the above Financial Policy and I understand and agree to the Financial Policy. Additionally, my signature authorizes Assignment of Benefits to Synergy PT, LLC and the release of all information necessary to secure the payment of benefits.

_____ _____/_____/_____

Signature (Patient or Responsible Party) **Date**

_____

Name (Please Print)

Please select the section that applies to your case and fill out the requested information

⑧ SELF PAY

Our office accepts cash, checks, Visa, MasterCard, and Discover

⑧ PRIVATE INSURANCE

Primary Policy or Medicare

Insurance Company _____

Address _____

City, State, Zip _____

Policy Holder _____

SSN and Date of Birth _____

Policy / ID Number _____

Group Number _____

Insurance Co. Phone _____

Secondary Insurance Policy (if applicable)

Insurance Company _____

Address _____

City, State, Zip _____

Policy Holder _____

SSN and Date of Birth _____

Policy / ID Number _____

Group Number _____

Insurance Co. Phone _____

I certify that I (or my dependent) have insurance coverage as noted above and assign directly to Synergy PT, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

_____ _____

Print Name **Responsible Party Signature**

_____ _____ _____

Policy Holder Date of Birth **Relationship** **Today's Date**