

S Y N E R G Y

WELCOME

ABOUT YOU

Today's Date: ____/____/____

Patient's Name: _____ Preferred Name: _____

Male Female Status: Single Married Divorced Separated Widowed

Birthdate: ____/____/____ Age: _____

Email _____

Cell Phone: _____

Work Phone: _____

Mailing Address: _____

City _____ State _____ Zip _____

Employer: _____ Occupation: _____

Reason For visit

The reason for this visit is a result of (Please Check): Work Sports Auto Trauma Chronic

Explain what happened: _____

Please describe the pain and its location: _____

When did the condition begin? ____/____/____

Is this condition getting worse? Yes No Constant Comes and Goes

Is this condition interfering with your (Please Check): Work Sleep Daily Routine

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a chiropractor before? Yes No

If so, whom? _____

Phone # _____

In the event of an emergency

Who should we contact: _____

Relation: _____

Home Phone: _____ Work Phone: _____

Who is your Medical Doctor: _____ Phone: _____

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Health history

Are you taking any of the following medications?

Nerve Pills Pain Killers (including aspirin) Muscle Relaxers Stimulants Blood Thinners
 Tranquilizers Insulin Other(s): _____

Do you have, or have you ever had any of the following diseases or conditions?

| | | | | | | | | |
|---|---|----------------------------|---|---|-------------------------|---|---|-------------------|
| Y | N | Heart Attack/Stroke | Y | N | Heart Surg./Pacemaker | Y | N | Heart Murmur |
| Y | N | Congenital Heart Defect | Y | N | Mitral Valve Prolapse | Y | N | Artificial Valves |
| Y | N | Alcohol/Drug Abuse | Y | N | Venereal Disease | Y | N | Hepatitis |
| Y | N | HIV +/-Aids | Y | N | Shingles | Y | N | Cancer |
| Y | N | Frequent Neck Pain | Y | N | Emphysema/Glaucoma | Y | N | Anemia |
| Y | N | High/Low Blood Pressure | Y | N | Psychiatric Problems | Y | N | Rheumatic Fever |
| Y | N | Severe/Frequent Headaches | Y | N | Kidney Problems | Y | N | Ulcer/Colitis |
| Y | N | Fainting/Seizures/Epilepsy | Y | N | Sinus Problems | Y | N | Asthma |
| Y | N | Diabetes/Tuberculosis | Y | N | Difficulty Breathing | Y | N | Chemotherapy |
| Y | N | Lower Back Problems | Y | N | Artificial Bones/Joints | Y | N | Arthritis |

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to:

List previous surgeries/treatments with dates:

List past serious accidents with dates:

Family Health History:

Are you on a special diet: Yes No If yes, since: ____/____/____

Do you smoke: Yes No How much: _____ How long: _____

Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

What is the age of your mattress: _____ Is it comfortable: Yes No

For Women:

Are you taking Birth Control Yes No

Are you pregnant: Yes No If yes, how long: _____ Nursing: Yes No

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Consent to use PHI & Authorization for Treatment

Acknowledgement for Consent to Use and Disclose Protected Health Information & Authorization for Treatment

Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Use and Disclosure of your Protected Health Information: Your protected Health Information will be used by Synergy, or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices: You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

Patient Initials

Requesting a Restriction on the Use and Disclosure of Your Information:

1. You may request a restriction on the use and disclosure of your Protected Health Information.
2. This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
3. If we agree to your request, the restriction will be binding with this office. Use or disclosure of Protected Health Information in violation of an agreed upon request will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas: Synergy utilizes common treatment rooms for restorative therapies including, but not limited to, Hyperbaric Oxygen Therapy, Micro-Current, Piezo Wave, Stim/Ultrasound, and Class IV Laser. A private treatment room can be provided upon request.

Resolution of Disputes: In the rare circumstance that a dispute arises regarding any matter connected with this office, I agree that independent arbitration will be entered into and completed before any legal action can be taken. I further understand that if I am not satisfied with the results of the arbitration, I am free to pursue any other legal remedy at that time.

(Female Patients ONLY) Verification of Non-Pregnancy: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed, at this particular time.

The date of last menstrual period _____(start/end).

Permission to Evaluate and Treat a Minor Child/ Dependent Adult: I authorize the office to evaluate and treat _____.

Revocation of Consent: You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation and consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information & receive treatment.

Patient or Legally Authorized Individual Signature

Date

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OFFICE FINANCIAL POLICY

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity and expertise required of the care rendered to you. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Our policy requires payment at time of service unless specific arrangements have been made in advance. Our agreement is with you and not your insurance company. Payment to our office is not contingent upon payment by your insurance company. You are considered a cash patient and you are financial responsible for you bill. If you do not pay your bill or set up a payment plan in a timely manner we will send you to collections.

If you have pre-paid for any services and do not receive them or if you cancel any pre-paid services, you will receive a pro-rated refund following a complete resolution of any outstanding payments.

If a check is returned, there will be a \$30 service fee charged.

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I have read and understand my financial responsibilities under this financial policy.

Guarantors Printed

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please ask the front desk if you are not the guarantor and will be using our services with the means to pay or if you would rather Synergy keep your **credit card on file** for convenience when you are treated.

## Late Policy for Chiropractic Appointments

Chiropractic adjustments are scheduled for 15-20 minutes. If you are 10 minutes late to your chiropractic appointment, we ask that you call to reschedule your appointment. This keeps the doctors on schedule and patient wait time down. You may also elect to see the doctor for a shortened appointment if needed. However, the full fee will still be collected.

## Cancellation Policy for Massage Appointments

All patients must cancel their appointment 24 hours before their scheduled appointment time. A 50% cancellation fee will be charged if the massage appointment is not cancelled within 24 hours of the massage appointment time.

Thank you for your cooperation,

Synergy Release Sports and Synergy Sports Wellness Institute

I am aware of the late policy for chiropractic appointments and cancellation policy for.

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_