

# S Y N E R G Y

## WELCOME

### ABOUT YOU

Today's Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Last

First

MI

Male  Female

Status:  Single  Married  Divorced  Separated  Widowed

Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_ Email \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone: \_\_\_\_\_

How Did You Hear About Us (Circle): Facebook Google Yelp Instagram Twitter Pinterest Other: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No If yes, how many? \_\_\_\_\_

### Sports

Affiliation: (ex, Alta Tennis) \_\_\_\_\_

Interests:  Golf  Tennis  Football  Soccer  Cheerleading  Running  Weight Training  Baseball

Other Interests: \_\_\_\_\_

Type of Injury: \_\_\_\_\_

Have you ever taken the Impact test (for concussion)? \_\_\_\_\_ If yes, when? \_\_\_\_\_

If you answered "Yes" to the above, please answer the following:

When was the concussion(s)? \_\_\_\_\_

Were you diagnosed? \_\_\_\_\_

How long did your symptoms last? \_\_\_\_\_

Have you been diagnosed or noticed yourself to have food allergies or sensitivities to food items?

If "Yes", who diagnosed you and what foods are you allergic or sensitive to? \_\_\_\_\_

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## 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: \_\_\_\_\_

# S Y N E R G Y

## 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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## Lifestyle

Do you take Supplements or Vitamins?  Yes  No

If so, what kind:  Multi  Energy  Anti-Inflammatory  Joint Care  Immune Building  Bone Care

Other: \_\_\_\_\_

Do you exercise regularly?  Yes  No

If yes, what type of exercise? \_\_\_\_\_

Do you have allergies?  Yes  No

If yes, for how many years? \_\_\_\_\_

Are you interested in weight loss?  Yes  No

Current Height \_\_\_\_\_ft \_\_\_\_\_in

Current Weight \_\_\_\_\_ lbs

## Pain chart

Please mark area(s) of injury or discomfort as show in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Description → Numbness

Pins & Needles

Burning

Aching

Stabbing

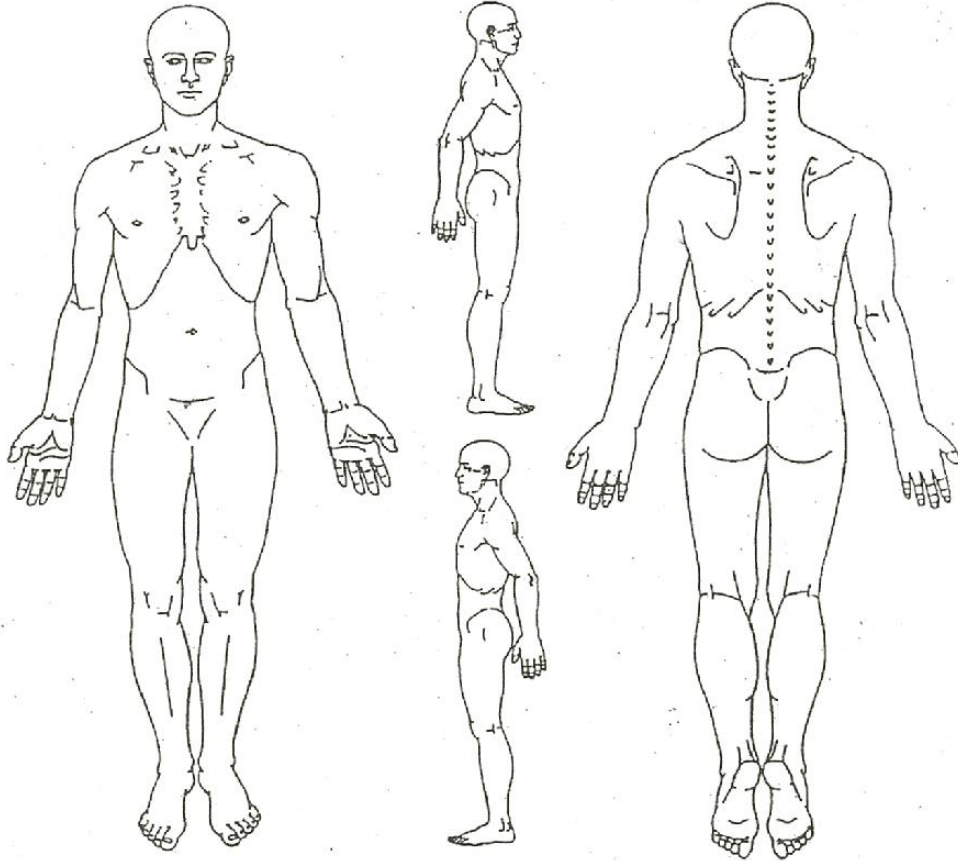
Symbol → NNNN

PPPP

BBBB

AAAA

SSSS



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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 your 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.

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

Guarantors Printed

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

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

**ONLY if the responsible party will not be present to make payment, you may leave your Credit Card information on file with us. We follow the PCI Regulations for your protection.**

American Express  MasterCard  Visa  Discover

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_ Billing Zip Code \_\_\_\_\_

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

## 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 \_\_\_/\_\_\_/\_\_\_\_\_