SYNERGY
PHYSICAL THERAPY AND PILATES

4300 MacArthur Ave., Suite 170
Dallas, TX 75209
Phone: 214-579-9781 Fax: 214-579-9673

Patient Information Form

***Please complete this form in its entirety and bring with you to your scheduled appointment*.**

Patient name: _____ Goes by: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Email address: _____

Male ☐ Female ☐ Cell # _____ Work # _____ Home # _____

Preferred Method of contact ☐Cell ☐home ☐work ☐email ☐text

Employer: _____ Occupation: _____

Parent/Guardian name: _____ Cell # _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

****

Primary Insurance: _____ **Secondary Insurance:** _____

Policy #: _____ Policy #: _____

Group #: _____ Group #:_____

Insured party: _____ Insured party: _____

Insured DOB: _____ Insured DOB: _____

****

Referring Physician: _____ Phone # _____

Address: _____City: _____ State: _____ Zip: _____

How did you hear about us: ☐Physician ☐Internet ☐Former Patient ☐Friend ☐Self ☐Other _____

_____ I do hereby consent to the evaluation and treatment by Synergy Physical Therapy and Pilates, LLC. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

_____ I authorize Synergy Physical Therapy and Pilates, LLC to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodians of records. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis.

_____ I consent to the release of my medical information to my (referring physician) _____ and (Insurance Company) _____ for communication and care coordination on my behalf.

ASSIGNMENT OF BENEFITS

I request that payment of the Medicare/Other Insurance benefits be made on my behalf to Synergy Physical Therapy and Pilates, LLC for any services furnished to me by Synergy Physical Therapy and Pilates, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

FINANCIAL AGREEMENT

The undersigned agrees, whether signing as an agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of Synergy Physical Therapy and Pilates, LLC. Synergy Physical Therapy and Pilates, LLC will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

CANCELLATION POLICY

_____ The undersigned is aware and agrees, whether signing as an agent or patient, to an out of pocket fee of $150 dollars for each scheduled appointment that is either missed without notice or cancelled without 24-hour notice. Synergy Physical Therapy and Pilates, LLC requires 24-hour notice for cancelled appointments.

The undersigned certifies the s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form. If patient/client is under the age the age of 18, guardian signature of consent is required

CONSENT TO TREAT A MINOR

I _____(Parent/Guardian) of a minor _____ (patient) receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

_____ (parents signature) Date: _____

NOTICE OF PRIVACY PRACTICES

_____ I acknowledge receipt of the Synergy Physical Therapy and Pilates, LLC, which I have received at the time of this admission or previously.

OUT OF NETWORK FILING:

If the undersigned is covered by an out-of-network insurance provider, the following amount $150.00 will be paid to Synergy Physical Therapy and Pilates, LLC upon the date of service.

_____ If the undersigned wishes for Synergy Physical Therapy and Pilates, LLC to file to the out of network plan and more than the $150.00 is allowed by the plan, the undersigned will be responsible for the difference.

The undersigned is aware that out of network filing for health insurance claims will be provided at request (via email) after patient discharge. Otherwise make an official request for filing to be provided on a monthly basis. If the patient/guarantor would like them provided on a monthly basis, please make request in writing.

_____ **Date:** _____

Signature of patient/guardian or Responsible Party

_____

Printed name of patient/guardian or Responsible Party

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General Health Questionnaire

Patient Name: _____ Date of birth: _____

Age: _____ Gender ☐ Male ☐ Female

Referring Physician _____ Primary Care Physician _____

Primary reason for seeking our services: ☐Back pain ☐Neck pain ☐Shoulder/Arm problems ☐knee pain

☐Ankle pain ☐Balance problems ☐Other _____ ☐Pilates

If an injury, please provide the following: _____ date of injury, _____

mechanism of injury, if not sure, how long has the problem persisted: _____

Do you currently experience any of these symptoms?

☐Fevers/chills/sweats ☐Unexplained weight loss/gain ☐Unusual fatigue ☐Nausea/vomiting ☐Headaches

☐Dizziness/light headedness/loss of consciousness ☐Blurred vision ☐Numbness/tingling/weakness
☐Chest pain/palpitations ☐Difficulty breathing/shortness of breath ☐Difficulty swallowing ☐Recent Falls
☐Changes in bowel/bladder function (starting/stopping)

If you answered yes to any of the above, please explain in detail: _____

_____

_____

Please list all surgical procedures (location and date): _____

_____

_____

Current medications: _____

_____

_____

Family medical history of medical problems (birth parents and siblings): _____

_____

_____

Do you feel safe at home: ☐yes ☐no – If no, please explain _____

Are you depressed: ☐yes ☐no – If yes, is this something you would like addressed? ☐yes ☐no

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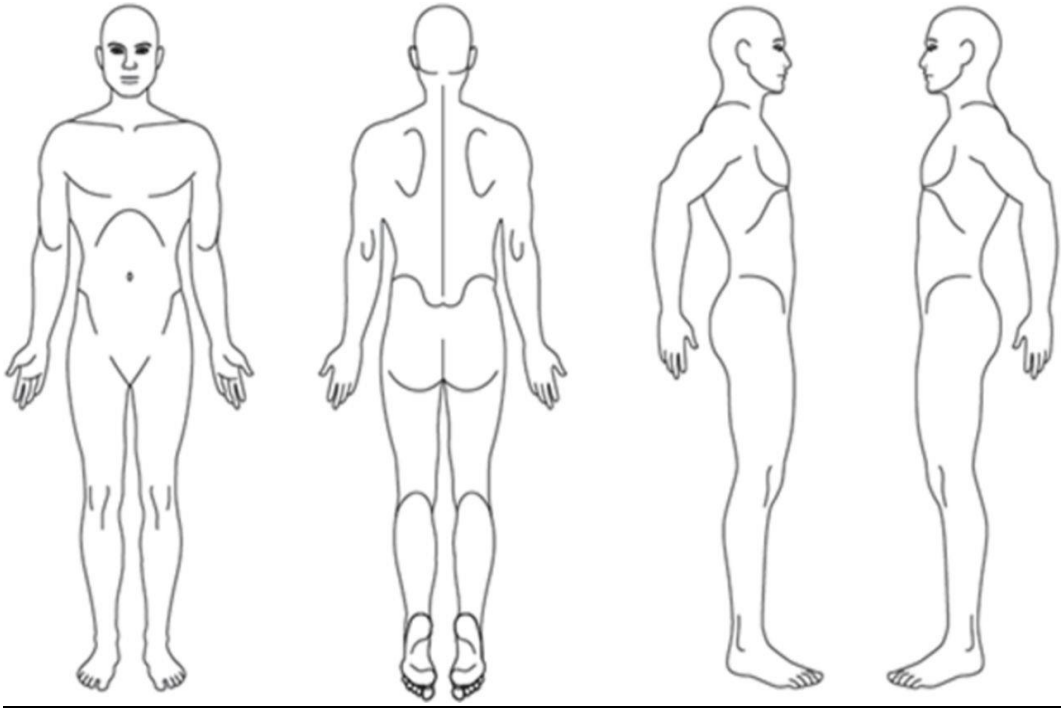
Pain Description

Describe your pain:
☐ Burning ☐ Dull ☐ Deep
☐ Aching ☐ Throbbing
☐ Sharp ☐ Other _____



Location: Circle or Mark on body

Pain Scale (0 is no pain, 10 is the worst imaginable)

Current Pain:

0 1 2 3 4 5 6 7 8 9 10

Lowest Pain:

0 1 2 3 4 5 6 7 8 9 10

Highest Pain:

0 1 2 3 4 5 6 7 8 9 10

Is there anything else you would like to disclose about your health status or previous health problems?

_____

_____

What are your goals you hope to achieve from receiving our services? _____

_____

_____

_____

_____

By signing this form, you confirm that the above information is correct and accurate to the best of my ability.

_____ Date: _____

Signature of Patient / Guardian