Welcome to Synergy Physical Therapy & Sports Medicine,

Thank you for selecting our team to treat your physical therapy needs. We would like to provide you some information about what to do before your first appointment and what to expect during your initial evaluation.

Pre-Appointment Preparations

The attached packet contains information about your upcoming visit and a questionnaire that we ask you to complete and return before your first visit. The information in the questionnaire will help save time on appointment day and you will have fewer forms to fill out when you arrive to our office.

You can return your completed registration paperwork through one of the following:

- Email: info@synergyptnc.com
- Fax: (888) 209-9322
- Mail: 233-E Bell Fork Rd., Jacksonville, NC 28540

Please try to answer all questions as best you can. It is important that we understand your medical history so we can provide the best treatment possible.

Appointment Day

Please arrive 30 minutes prior to your appointment to allow ample time to ensure your new patient documents are complete. We value your time and will make every effort to stay on schedule to avoid unnecessary delays.

If you were able to complete your patient portal registration online then please arrive 15 minutes prior to your appointment to allow necessary time for processing.

If you are not able to make your appointment, please call us at (910) 238-2259 and our team will be happy to assist you with rescheduling your visit.

Sincerely, The Synergy Team

SYNERGY physical therapy & sports medicine

Patient Registration Form

Today's Date: _____

Instructions for Completion

All Patients will complete the Patient Information and Condition / Referral Information Sections. Depending on the method you intend to pay for services rendered, you will complete the Insurance Info., the Worker's Comp Info., the Accident / Liability Info., or the Self-Pay Info. section. Sign & Date. Please write legibly with a blue or black pen, for questions contact our office at (910) 238-2259.

Patient Information

Gender

Last Name:_____ First Name:_____ MI:_____ (Male / Female)

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

Date of Birth:_____ SS#:_____ Employer:_____ (PT / FT)

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address: _____ Best Contact: Home / Work / Cell / Text / Email

Check Appropriate Line: ____ Minor (Under 18) ____ Single _____ Married _____ Widowed _____ Divorced _____

Parent/Guardian Name (If Minor):_____ Contact #:_____

Emergency Contact Name:_____ Contact #:_____ Relationship:_____

Condition / Referral Information

Problem Description:_____ Date of Onset:_____ Surgery Date:_____

Referred By: _____ Facility Name: _____

Facility Phone #: _____ Date of Last Visit:_____ Date Next Visit:_____

Primary Care Provider:_____ Facility Name:_____

How Did You Hear About Us (Optional): ___ Referring Provider ___ Family or Friend (Name:_____)

___ Advertisement ___ Brochure ___ Internet ___ Insurance/Directory ___ Other: _____

Insurance Information

Primary Insurance: Subscriber

Insurance Co: _____ Deductible: _____ Name: _____

ID #: _____ Max Benefit: _____ Relationship: _____

Group #:_____ Copay: _____ Coinsurance %: _____ Date of Birth: _____

Contact #: _____

Secondary Insurance: Subscriber

Insurance Co: _____ Deductible: _____ Name: _____

ID #: _____ Max Benefit: _____ Relationship: _____

Group #:_____ Copay: _____ Coinsurance %: _____ Date of Birth: _____

Contact #: _____

I acknowledge that the information provided above is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Patient Name (Print): _____

Parent or Guardian Signature (if patient is a Minor): _____ Date: _____

Parent or Guardian Name (Print): _____

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Patient Registration Form

Page 2. Patient Name: _____

Worker's Comp Information

Related to Work: ___ Yes Date of Injury: _____ ___ No (If No, please skip this section)

If Yes, Name of Employer: _____ Phone #: _____ Claim #: _____

W/C Ins. Co.: _____ Ph #: _____ Case Mgr: _____ Ph #: _____

Accident / Liability Information

Date of Accident or Injury: _____ ___ Motor Vehicle Accident ___ Other: _____

If Motor Vehicle Accident, Please fill in your personal Motor Vehicle Policy or the Policy of the Owner of the Vehicle in which you were a passenger. We do not bill any Third Party due to the fact they pay directly to you or your attorney upon settlement only.

Auto Insurance Carrier or Liability Coverage Name: _____ Claim #: _____

Adjuster Name: _____ Phone #: _____ What state did accident occur: ____

Medical Payment Available?: Yes / No If yes, please give amount: _____

If you have an Attorney or plan to obtain one, please ask our receptionist for a "Letter of Protection and Attorney Lien Forms"

Attorney Name: _____ Attorney Phone #: _____

Self-Pay Information

I agree to pay for all services rendered out of pocket without the aid of insurance or legal proceedings. YES / NO

____ I would like a 30% discount by paying for my treatment at the time of service.

____ I would be interested in establishing a payment plan for services rendered.

____ I would be interested in learning about Financial Hardship programs.

Tertiary Insurance: Subscriber

Insurance Co: _____ Deductible: _____ Name: _____

ID #: _____ Max Benefit: _____ Relationship: _____

Group #:_____ Copay: _____ Coinsurance %: _____ Date of Birth: _____

Contact #: _____

To expedite your New Patient Processing, please fax or email these completed forms prior to your first visit.

Fax: 888-209-9322

Email: info@synergyptnc.com

SYNERGY physical therapy & sports medicine

NEW PATIENT HISTORY AND PHYSICAL FORM

Today's Date: _____ **Date of Birth:** _____

Patient Name: _____ Preferred Name: _____

Please complete the following questions to the best of your ability so that we can develop a treatment plan to meet your individual needs.

Chief Complaint (Why are you here today?):_____

Location of pain/problem:_____

Date of Injury or **When** the problem began:_____

How did the problem **start**:_____

Have you been treated for **this current problem before**? _____ If yes, When?_____ How?_____

Please rate your **pain** using the following scale: **0 = No Pain** **10 = Most Severe Pain**

At Best: 0 1 2 3 4 5 6 7 8 9 10 **At Worst:** 0 1 2 3 4 5 6 7 8 9 10

What makes it **better:**_____**worse:**_____

What does the pain **feel** like (throbbing, burning, sharp, etc)?_____

What are your goals for physical therapy? _____

Are you currently working? _____ Occupation and physical demands:_____

Work Status: Full time Part time Medical restrictions Medical Leave Other:_____ Last date worked:_____

Hobbies/Recreational Activites/Exercise:_____

GENERAL MEDICAL INFORMATION

My general health is (Circle one): Excellent Very Good Fair Poor

ALLERGIES: List medications/foods/tape/**Latex** or other items you are **ALLERGIC** to or have had a bad reaction to:

_____

What kind of reaction did you have?_____

Are you currently **PREGNANT**? Yes No Due Date: _____ # of weeks gestation: _____

PAST MEDICAL HISTORY (Please check box if you have ever been diagnosed with the following):

☐	Arthritis (RA or OA)	☐	Pacemaker	☐	Frequent/recurring headaches
☐	Cancer	☐	Metal Implants	☐	Head Injury
☐	Diabetes	☐	Thyroid problems	☐	Anxiety
☐	Stroke/TIA	☐	Osteoporosis/Osteopenia	☐	Depression
☐	Heart Attack	☐	Blood Clots	☐	PTSD
☐	Heart Disease	☐	Asthma/Emphysema	☐	Dizziness
☐	High Blood Pressure	☐	Fibromyalgia	☐	Seizure
☐	Infectious Disease	☐	Orthopedic problems	☐	Multiple Sclerosis
☐	Autoimmune Disease	☐	GI Problems	☐	Drug/Alcohol Dependency
☐	Liver Disease	☐	Gout	☐	Other:
☐	Kidney Disease	☐	Peripheral Vascular Disease	☐	Other:

Surgical History (list type of surgery and date):_____

_____

List other pertinent information your Therapist should know:_____

_____

I hereby attest that I personally completed this form and all the information is true and accurate.

_____ _____

Signature of Patient or Guardian completing form Date

Synergy Physical Therapy & Sports Medicine Informed Consent and Policies Agreement

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measureable and track-able?

If the above criteria are not met, you are welcome to participate in our elective "cash pay" services such as the Multi-Radiance low level cold laser, fitness/exercise training, Functional Movement screening, running evaluations, wellness/nutrition counseling, etc. Elective services *will not* be billed to insurance. We will collect for these elective services at each appointment or session. Discounted packages must be purchased in advance.

Results

The purpose of physical therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time

Informed Consent

By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.

Patient Declaration

I confirm that I have read and fully understand this consent for care and policies form.

I have read and understand the foregoing explanation of rehabilitation or therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

_____
Patient/Guardian Signature & Date

_____
Witness Signature/Date

Financial Policy and Assignment of My Benefits

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our **Financial Policy** that we require you to read and sign prior to any treatment.

- I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to **Synergy Physical Therapy & Sports Medicine** for any charges not covered by health care benefits.
- It is my responsibility to notify **Synergy Physical Therapy & Sports Medicine** of any changes in my health care coverage.
- We cannot bill your insurance unless you provide us with your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.
- The patient's personal portion will be due at each visit and is collected by the front desk. We accept cash, check, MasterCard, Visa and Discover. ***Please be advised we are estimating your personal portion.*** This is based on the information received when benefits were quoted by your insurance. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Final balances will be determined once your insurance finishes processing. At that time, outstanding balances will be collected or overpayments will be refunded.
- Copays, coinsurance payments and deductible payments are due upon arrival- if you happen to forget your wallet or checkbook we may still be able to see you upon completion of a special "Extension request" form. This is a "promise to pay" form and carries a minimal fee that allows you to keep your appointment.

I am responsible for the entire bill or balance of the bill as determined by **Synergy Physical Therapy & Sports Medicine** and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained for all payment for medical services supplied or received.

Dated this _____ day of _____, 20_____.

_____ _____ _____
Signature of Policyholder Witness Signature of Claimant, if other than Policyholder

Important Company Policies for a Successful Relationship

Welcome to **Synergy Physical Therapy & Sports Medicine.** We strive to provide you with the most innovative and personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom of this form. Please feel free to ask any questions regarding the following policies.

Initial All Boxes

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. Please call in advance if you think you will be late for your scheduled appointment, and we will do our best to accommodate your needs.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment, we require a minimum ***24-hour advance notice***. Anything less will result in a ***$25 fee*** charged to your account. Payment is due before being seen for your next appointment. These charges are the patient's responsibility and cannot be billed to your insurance company or work comp carrier. Advance notice allows someone else (who is often in pain and needs the treatment) time to reserve the appointment in place of you. Please be courteous and responsible. Thank you.

☐ **No-shows for scheduled appointment are not tolerated**
If you fail to attend a scheduled appointment and do not call in advance to cancel it we record it as a "no show". If you "no show" we reserve the right to remove all future appointments from the schedule and discharge you from our care. A ***$50 re-instatement fee*** will be assessed to your account in order to get back on our schedule. You may re-schedule appointments again on a "first come, first serve basis". We also reserve the right to inform your referring medical provider that care has been discontinued due to "non-compliance" with the prescribed order. If you are a Worker's comp patient, we are obligated to inform your case manager/adjustor of every missed appointment and you are personally responsible for any fees charged for re-instatement.

☐ **Cell phones must be on silent or shut OFF.**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, how- ever, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
We do not provide childcare services. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal & State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A (a) (5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please contact these offices for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: (202) 619-1343, by fax: (202) 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, (202) 619-0089."

Minors and Parents

If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments. The front office and treating therapist must have a working contact number to reach you in the rare event of an emergency if you chose not to stay on site during their treatment. Please be aware of our hours of operation – minors left on site for treatment must be picked up by closing time.

☐ I have read and agree to all the policies on this form. Signature_____ Date: _____

Current Medication List

Must include all prescriptions, over-the-counters, herbals,
vitamin/mineral/dietary (nutritional) supplements

Patient Name: _____ Date: _____

Medication Name	Dosage	Frequency
example: Tylenol	250mg	as needed