○ SYNERGY PHYSICAL THERAPY ○
7625 Maple Lawn Blvd Suite 140, Fulton, MD 20759-2565 ● Tel: (301) 497-3070 ● Fax: (301) 497-3071

BILLING AND INSURANCE INFORMATION

Please present insurance card, ID card and prescription at time of check-in

PATIENT DEMOGRAPHIC INFORMATION

If you haven't done so already, please complete online intake form that was emailed to you previously.

RESPONSIBILITIES AND CONSENT

1. Financial Responsibility

I certify that the information I have provided regarding my insurance coverage is correct and authorize Synergy Physical Therapy to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies

I authorize that payments be made directly to Synergy Physical Therapy for all medical insurance benefits which are payable under the terms of my insurance policy for the services provided.

I agree to pay any copayments, coinsurance, or deductible as required by my insurance plan for medical care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan.

I acknowledge full financial responsibility for services rendered by Synergy Physical Therapy. I further guarantee the full and complete payment of all charges for medical services rendered by Synergy Physical Therapy. This is a guarantee of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges. I understand that I may be asked to sign a Payment Schedule Agreement for any overdue balances.

Synergy Physical Therapy may impose reasonable interest (1.5% per month), late charges, direct collection agency costs (35%-50% whichever applicable) and or reasonable attorney's fee should my account become delinquent (>30 days of the date of the statement)

Synergy Physical Therapy may impose a late cancellation fee of $25.00 for appointments not cancelled 24 hours in advance and no show fee of $40.00. There will be a $35.00 fee assessed for all returned checks.

2. Release of Medical Information for Billing

I hereby authorize Synergy Physical Therapy to submit a claim to my insurance company, health and welfare fund, Medicare or Medicaid for medical services provided to me or my dependent. I also authorize Synergy Physical Therapy to provide a copy of this release and a copy of medical records related to such services if requested by the payor. Further, I authorize Synergy Physical Therapy to release medical information to my consulting or primary care physician (PCP) to assist with continuity of my health care. This release will expire one year from the date of my signature below unless I cancel this release in writing prior to that date.

3. Non-covered Services

I understand that some benefits are not covered under my plan, and coverage determinations and payments of claims are subject to all the eligibility, coverage, exclusions, and limitations listed in my contract with my insurance carrier. I further understand that I may be charged for services which may be deemed as medically unnecessary by my insurance carrier. I assume full financial responsibility for medical services provided to me or my dependent which are not covered by the benefits in my insurance plan.

4. Notice of HIPPA

I acknowledge that I have received/reviewed Synergy Physical Therapy's Notice of Privacy Practices. I have been given the opportunity to ask ay questions I may have regarding this notice.

5. Inherent Risk

I understand that rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls and similar injuries, and that the only alternative to entirely avoiding these risks would be to forgo rehabilitation altogether. I, therefore, acknowledge that falls are an inherent risk of the rehabilitation process, and I accept the risk.

I agree to the Above Stated Responsibility and Consent.

I also agree that the information completed online via intake form was completed by me (or parent/guardian/personal representative) and is true and correct to the best of my knowledge.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Printed Name of Patient, Parent, Guardian, or Personal Representative Date

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CONDITION

Please answer the following questions to the best of your knowledge to help us serve you better.

Height: | Weight:

Reason for visit (please describe your chief complaint and history of present injury/symptoms):

When did your injury/symptoms first appear or change in status?
Date (mm/dd/yyyy):

☐ chronic ☐ insidious (no known cause, gradual development)
☐ new injury

Is this condition getting progressively worse?
☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): (circle one)

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

Does it interfere with your:
(please check all that apply) ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform or aggravate your symptoms: (please check all that apply)
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down
☐ Rising from a chair ☐ Coughing/Sneezing ☐ Other _____

Alleviating factors: (please check all that apply)
☐ Rest ☐ Heat/Ice ☐ Anti-inflammatory Medication ☐ Other _____

What treatment(s) have you already received for your condition? (check all that apply)
☐ Medications ☐ Surgery (date of surgery (mm/dd/yy: _____)
☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

Have you been hospitalized for this condition? If so, please write dates of prior hospitalization:
From (mm/dd/yyyy): To (mm/dd/yyyy):
--- ---
Have you received any specific orders (things to do or avoid) from your physician? If, yes, write it below.

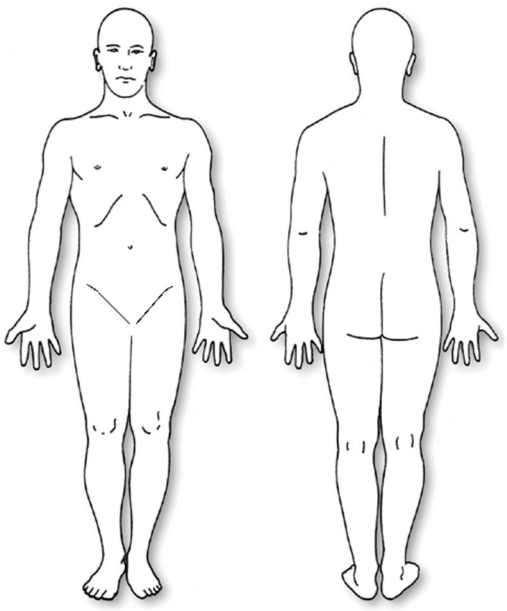
Any prior history of similar symptoms? ☐ Yes (If YES, answer next question) ☐ No
- How many prior episodes (occurrences) of current condition have you had in the past? (please check one)
☐ 1-5 ☐ 6-10 ☐ 11+ Year of first episode? _____

What type of prior treatment have you had for similar symptoms?

Please list any diagnostic studies you may have had for your current condition:
☐ X-ray ☐ CAT-Scan ☐ MRI ☐ EMG ☐ Other _____

Please list health care providers you are currently seeing for your current condition (if any)

Mark an 'X' on the picture where you continues to have pain, numbness, or tingling



Type of Pain:
(please check all that apply)

☐ Sharp	☐ Dull	☐ Throbbing
☐ Numbness	☐ Aching	☐ Shooting
☐ Burning	☐ Tingling	☐ Cramps
☐ Stiffness	☐ Swelling	☐ Other
☐ Tenderness	☐ Spasm	_____

Pain is	Worst	Best
In the morning		
During the day		
At night		

How often do you have this pain?

Is it consistent or does it come and go?

Please list any medication(s) you are currently taking :
☐ High Blood Pressure ☐ Anti-inflammatory ☐ Muscle relaxants ☐ Pain Medication ☐ Other _____

Are you currently pregnant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

For Medicare patients only:

Are you receiving home health now or have you received it in the past 60 days? Yes / No

If yes, write name of home health agency and last visit date _____

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OCCUPATIONAL/SOCIAL HISTORY

Living Arrangements: (please check all that apply): ☐ Spouse ☐ Partner ☐ Children ☐ Other _____	Home Layout: ☐ Condo/Apt: floor # _____ With/Without Elevator (circle one) ☐ Single-Family or Townhouse, Approximate # of steps to enter _____
Name of Occupation:	Are you currently employed: ☐ Full Time ☐ Part-Time ☐ Retired ☐ Out of Work Since(mm/dd/yyyy) _____ If a return-to-work date is known, please list here: (mm/dd/yyyy) _____ Duty Level: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy
Is the condition related to: Worker's Compensation? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No (If yes, please fill out 'injury info' form)	Do you use any assistive devices? (please check all that apply) ☐ Cane ☐ Crutches ☐ Walker ☐ Rolling Walker ☐ Rollator ☐ Wheelchair ☐ Motorized Scooter ☐ Other _____
Do you have a history of falls? ☐ Yes ☐ No If yes, how many times? _____ Approx date of last fall: _____	Current functional limitations: (please check all that apply) ☐ Self-Care ☐ Mobility: Walking/Moving Around ☐ Changing/Maintaining Body Position ☐ Carrying, Moving & Handling Objects ☐ Other _____

HEALTH HISTORY

Have you or your immediate family member had any of the followings : (please check all that apply)

	You	Family	
Cancer	☐ Yes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ Yes	☐ No
Diabetes	☐ Yes	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ Yes	☐ No
Chest Pain / Angina	☐ Yes	☐ Yes	☐ No
Stroke	☐ Yes	☐ Yes	☐ No
Arthritis	☐ Yes	☐ Yes	☐ No

Have you had recently or do your experience : (please check all that apply)

Nausea / Vomiting	☐ Yes	☐ No
Fevers / Chills	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Unexplained Weight Loss	☐ Yes	☐ No
Numbness / Tingling	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Bowel/Bladder Changes	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

Have you had any of the following surgeries : (please check all that apply)

Neck	☐ Yes	☐ No
Low Back	☐ Yes	☐ No
Chest	☐ Yes	☐ No
Heart	☐ Yes	☐ No
Abdominal	☐ Yes	☐ No
Upper Extremity	☐ Yes	☐ No
Lower Extremity	☐ Yes	☐ No
C-Section	☐ Yes	☐ No
Hysterectomy	☐ Yes	☐ No

Do you have a history of any of the followings : (please check all that apply)

Shortness of Breath	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Polio	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Fibroids	☐ Yes	☐ No
Irritable Bowel Syndrome	☐ Yes	☐ No			

Exercise ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Habits ☐ Smoking _____ Packs/Day ☐ Alcohol _____ Drinks/Week

"Thank you so much for taking the time to give your therapist this valuable information about you "

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NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Electronic Communication Consent
We may communicate with you via emails and texts to send appointment reminders, to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you, and to collect/receive your feedback/response regarding our services.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the follow purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command and authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers' Compensation: We may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.
Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.
Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.
Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

If you have any questions, requests, complaints, please contact the Privacy Officer:
Michelle Kim, 7625 Maple Lawn Blvd, Suite 140 Fulton, MD 20759

I agree to the Above Stated Notice of Privacy Practices.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

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Patient Rights and Responsibilities

To our patients:
Thank you for choosing Synergy Physical Therapy. In order to serve you best, we would like you to be aware of the following:

VISITORS: All "non-patients' should remain in waiting area during treatment hours. Behavior of patients and relatives must be reasonable, responsible and considerate of the rights of other patients and personnel.

APPOINTMENTS: From the time of the original evaluation, success towards achievement of many of your rehabilitation goals requires your attendance and diligent efforts. Failure to attend scheduled appointments creates the risk of not fulfilling those goals. It also affects other patients that were not able to get scheduled a particular day and time due to such time slot being occupied by your missed appointment. It is recognized by management that patients may need to cancel on occasion, but it is hoped that this is a rare event, and not a repeated one.
For the benefit of all of our patients who need to have their appointments at specific times, we have instituted a fee for those who have repeatedly cancelled or failed to show for appointments without notifying this office at least 24 hours in advance. The Manager may therefore charge a cancellation fee of $25.00 and a no show fee of $40.00 for failure to notify us of your inability to attend with such proper notice. **If you are more than 15 minutes late, you may be asked to reschedule** and late fee of $25.00 may be assessed**.** Call us as soon as possible if you cannot make your appointment and please be prepared to reschedule at that time.
The conditions below may result in you being discharged from physical therapy as they show lack of attendance and non-compliance with our plan of care. At that point, a new prescription would be required to restart physical therapy.
(1) multiple late cancellations (3 or more) or
(2) 2 consecutive no shows or
(3) unexplained absence for more than 2 weeks

INSURANCE COVERAGE: **It is your responsibility to contact your insurance company and find out what your benefits are for outpatient physical therapy.** Although our staff may obtain this information for you, it is only a quote of benefits that is advised to us by your insurance company, and is not a guarantee of payment. We are not financially responsible for your financial cost that incurs due to the inaccurate benefit information presented to us or to you by your insurance company.

Communication is a crucial aspect of your care. Please inform your therapist ASAP if you are unhappy with your progress or plan of care in physical therapy.

If you have any questions, please feel free to ask! We are here to help! Thank you.

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Printed Name of Patient, Parent, Guardian, or Personal Representative Date