synergy
manual physical therapy
restore. relieve. recover.

## PATIENT DEMOGRAPHICS

| | | | |
|---|---|---|---|
| DATE: | LAST NAME: | FIRST NAME: | |
| HOME ADDRESS: | | | |
| CITY: | | STATE: | ZIP CODE: |
| DOB: | SSN: SEX: | EMERGENCY CONTACT: | PHONE: |
| HOME PHONE: | CELL PHONE: | EMAIL: | |

DO WE HAVE PERMISSION TO TEXT YOU? YES/NO DO WE HAVE PERMISSION TO LEAVE A VOICEMAIL? YES/NO

DO YOU PREFER EMAILED OR MAILED STATEMENTS? EMAILED MAILED

MY PRONOUNS ARE: [HE/HIM/HIS] [SHE/HER/HERS] [THEY/THEM/THEIRS] [ZE/HIR] OTHER:_____

RELATIONSHIP STATUS: [SINGLE, NEVER MARRIED] [DIVORCED] [MARRIED] [CIVIL UNION] [DOMESTIC PARTNERSHIP/LIVING WITH PARTNER] [WIDOWED/GRIEVING THE LOSS OF A PARTNER] [DECLINE TO ANSWER]

WORK STATUS: FULL-TIME PART-TIME NOT EMPLOYED RETIRED MEDICAL LEAVE

| | |
|---|---|
| EMPLOYER: | JOB TITLE: |
| REFERRING PROVIDER: | PRIMARY CARE PROVIDER: |

## PRIMARY INSURANCE INFORMATION

| | |
|---|---|
| PRIMARY INSURANCE: | POLICY ID#: |
| SUBSCRIBER NAME: | SUBSCRIBER DOB: |

## SECONDARY INSURANCE INFORMATION

| | |
|---|---|
| SECONDARY INSURANCE: | POLICY ID#: |
| SUBSCRIBER NAME: | SUBSCRIBER DOB: |

## WORK RELATED INJURIES

| | | |
|---|---|---|
| WAS THIS A WORK RELATED INJURY: YES NO | DATE OF INJURY: | CLAIM #: |

## AUTO INJURIES

| | | |
|---|---|---|
| WAS THIS AN AUTO INJURY? YES NO | DATE OF INJURY: | CLAIM #: |
| ADJUSTER'S NAME: | ADJUSTER'S PHONE #: | |
| IS AN ATTORNEY INVOLVED IN YOUR CASE? YES NO | ATTORNEY'S NAME: | |

## PREVIOUS TREATMENT

| | | |
|---|---|---|
| HAVE YOU RECEIVED PREVIOUS PHYSICAL THERAPY TREATMENT? YES NO | WHAT AREA WAS TREATED? | DATES OF TREATMENT: |

## AUTHORIZATION TO TREAT AND RELEASE MEDICAL INFORMATION

- I CONSENT TO TREATMENT BY SYNERGY MANUAL PHYSICAL THERAPY
- I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO MY INSURANCE COMPANY FOR THE MAINTENANCE OF MY HEALTH, OR THE PROCESSING OF ANY INSURANCE CLAIM.
- A COPY OF THIS FACILITIES "STATEMENT OF PRIVACY NOTICE" HAS BEEN PROVIDED TO ME.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

# Pelvic Floor Intake Form

**Current Symptoms: Check all that may apply**

___Urinary leakage  If yes, approximately how many leaks per day? ___ How many pads per day? ___

___ Fecal incontinence

___ Urinary urgency

___ Constipation

___ Pelvic pain

___ Pain with intercourse

**History: Check or add any medical related diagnoses**

___ Endometriosis

___ Interstitial Cystitis

___ Ulcerative Colitis

___ Irritable Bowel Syndrome

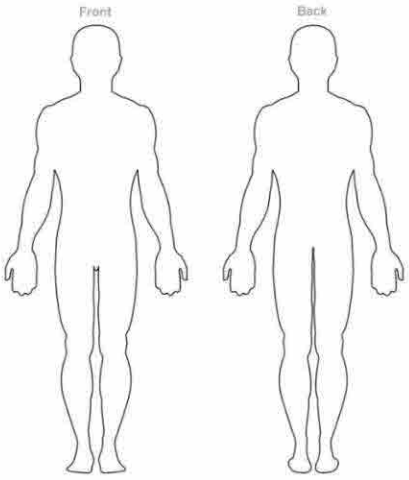
___ Cancer  If yes, what kind? _____

___ Abdominal or pelvic surgery  If yes, what kind? _____

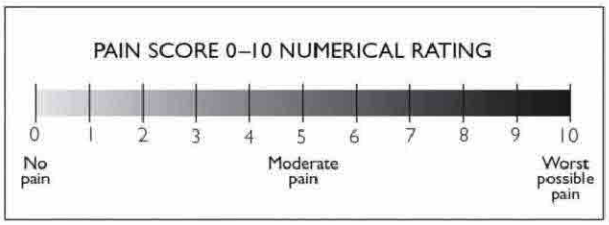
___ History of childbirth?  If yes, how many? _____

___Other: _____

Please mark any other areas of concern on the body chart to the right you may have at this time:




Rate your pain from 1-10 using the scale below.



synergy
manual physical therapy
restore. relieve. recover.

## MEDICAL HISTORY

| DATE: | LAST NAME: | FIRST NAME: |
|---|---|---|
| | | |

**CIRCLE ANY CONDITION YOU HAVE HAD:**

| | | |
|---|---|---|
| CANCER | HIGH CHOLESTEROL | MULTIPLE SCLEROSIS |
| DIABETES | HEART DISEASE | COPD |
| DIZZINESS | PACEMAKER | HIV/AIDS |
| OSTEOPOROSIS | STROKE | DEPRESSION |
| OSTEO-ARTHRITIS | BOWEL/BLADDER CHANGES | ANXIETY |
| RA | VASCULAR DISEASE | ASTHMA |
| HIGH BLOOD PRESSURE | HEAD INJURY | HEPATITIS |

**LIST ANY SURGERIES AS IT RELATES TO YOUR CURRENT CONDITION:**

_____

_____

**FALL HISTORY:**

HAVE YOU HAD ANY FALLS IN THE PAST YEAR? YES NO

IF YES, HOW MANY? _____

IF YES, ANY INJURIES? YES NO

**MEDICATIONS TAKEN (PLEASE INCLUDE NAME, DOSAGE, FREQUENCY AND ROUTE OF ADMINISTRATION)**

_____

_____

_____

_____

_____

_____

**MEDICAL ALLERGIES (DRUGS, LATEX, ADHESIVES, CHEMICALS):**

_____

_____

**PLEASE NOTE ANY ADDITIONAL INFORMATION THAT WOULD ASSIST US IN YOUR CARE (APPREHENSIONS, SPECIAL NEEDS AND OR RELIGIOUS OR CULTURAL CONSIDERATIONS):**

_____

_____

_____

**WHAT IS YOUR GOAL FOR PHYSICAL THERAPY?**

_____

_____

_____

_____

BY SIGNING BELOW, I COMMIT TO MY PHYSICAL THERAPY PROGRAM. THIS INCLUDES ATTENDING SCHEDULED APPOINTMENTS AND BEING COMPLIANT WITH MY HOME EXERCISE PROGRAM. I WILL INFORM MY THERAPIST SHOULD MY CONDITION CHANGE.

_____ _____

**SIGNATURE OF PATIENT OR GUARDIAN** **DATE**

synergy
manual physical therapy
restore. relieve. recover.

## INTRAMUSCULAR MANUAL THERAPY CONSENT FORM

Intramuscular Manual Therapy (IMT) involves placing a small needle into the muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing symptoms. Because the needles are so thin, the patient often does not even feel the needle go in, but will quickly feel the relief of the muscle relaxing. This treatment may be appropriate for the treatment of your dysfunction, but your therapist will discuss the treatment before performing the technique with your consent.

IMT has been a valuable treatment for musculoskeletal pain here in Colorado since 2005. It is a beneficial treatment for chronic back pain, osteoarthritis, headaches, sciatica, and tendonitis. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

## RISKS OF THE PROCEDURE:

The most serious risk associated with IMT is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising and/or infection. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily fluids?

YES NO

**If you marked yes, please discuss with your practitioner.**

Please sign and date acknowledging that you have read and understand the risks involved with IMT treatment. By signing this consent form you are not required to receive the IMT treatment and can start or stop treatment at any time by discussing your treatment with your practitioner.

_____

Printed Name

X_____ _____

Signature Date

## SYNERGY MANUAL PHYSICAL THERAPY FINANCIAL POLICIES & PRACTICE POLICIES

We are pleased to have you as a patient and will make every effort to make our services accessible. If at any time, you find it difficult to make your payments, please discuss this with us. Co-payments and supply fees are due at the time of service. Claims will be submitted to your insurance company. You will be responsible for paying your annual deductible, co-payment, and/or co-insurance.

### INSURANCE

The patient is responsible to make available to the practice, complete insurance information, for accurate filing of claims. Insurance information includes referrals from other providers for primary and secondary insurance coverage, all identification and benefit cards or documents. The patient agrees that if the insurance company denies benefits for any reason, that he/she is responsible for the full amount of the bill immediately. **For services not covered by the patient's benefit plan, payment is due at the time of service.**

### PPO & HMO INSURANCES

If the practice has an agreement with the patient's insurance carrier, we will accept payment from the carrier for services covered by the patient's benefit plan. Deductibles, co-insurance and co-payments are due at the time of service and are collected before the service is provided.

### INDEMNITY INSURANCES

Insurance payments received by the Practice will be applied to the patient's account and the patient agrees to pay the balance. Deductibles, co-insurance and co-payments are due at the time of service and are collected before the service is provided.

### MEDICARE INSURANCE

The practice accepts assignment from Medicare. Therefore, the patient agrees to pay the practice the Medicare co-insurance including any amount of the patient's deductible that is not yet satisfied. Any procedures not covered by Medicare may be due at the time of service. If you have a supplemental policy in which the Medicare carrier automatically sends the claim, we are required to keep a separate signature on file.

X_____ _____

Sign name as it appears on supplemental insurance card (Medicare patients only) Date

I authorize the practice to release any medical information to my supplemental insurance for determination of of benefits or benefits payable for related services.

### NON-CONTRACTED INSURANCE

The patient must recognize that he/she is responsible to pay the full amount, due at time of service, unless the practice has an agreement with the patient's insurance carrier for alternative payments. As a courtesy, the practice will file insurance claims with all standard insurance carriers.

### CANCELLATION/NO SHOW FEES

Please provide our office with 24-hour notice to change or cancel an appointment. **Patients who do not attend or provide 24-hour notice to change a scheduled appointment will be assessed a $80 fee**. Your treatment plan has been established by your medical practitioner(s) to get you back to your regular activities as quickly as possible. Missing appointments hinder that process and may end up prolonging your recovery. Initals:

### SELF PAY PATIENTS

If you are a self pay patient, you will be responsible for payments at the time of service. We will not bill insurance for any services provided and you may not submit for reimbursement from your insurance company. Please refer to the "Self Pay Patient Notice" for specific information related to your treatment at our facility.

### PAST DUE ACCOUNTS/ RETURNED CHECKS

If a collection agency or attorney must be used to collect a debt on a past due account, you agree to pay all the collection costs, attorney's fees, and court costs associated with the collection. All returned checks will be charged the original amount plus a $35 non-sufficient funds fee.

### SUPPLY FEES

If you received the following services a supply fee will be assessed and due at the time of service.

**KINESIO TAPE $10.00** **IONTOPHORESIS $15.00**

**I have read, understand and agree to comply by the policies listed above.**

_____ X_____ _____

Printed Name Signature of Patient or Responsible Party Date

# CREDIT CARD TRANSACTION AUTHORIZATION FORM

Synergy Manual Physical Therapy
Authorization for Credit Card

**AUTHORIZATION:**
Until further notice, I authorize Synergy Manual Physical Therapy to charge the patient responsibility balance on my account to the following credit card:

**CIRCLE ONE:** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

**Last Four Digits of Credit Card Number: _____**

**Expiration. Date (mm/yy): _____**

Per insurance contractual obligations, a patient's co-share is due at the time of service. Self pay balances are due at the time of service per the Self-Pay Agreement. If I do not pay my co-share or self pay balance at the office at the time of my appointment, I understand my credit card will be charged immediately. No statement will be sent for co-share or self pay balances.

I understand that once the health plan has paid their portion for my care, I will receive an Explanation of Benefits (EOB) from them. The health plan's EOB will state any remaining balance to be paid by me. Our billing software, will email/or send a statement to the email/physical address below with my balance due. I understand that I have 30 days to pay the statement or communicate with Synergy Manual Physical Therapy regarding any discrepancies discovered or to set up a payment plan. I understand that my statement may include "No Show" fees, non-covered services (i.e. dry needling) fees or supply fees not paid at the time of service or by my insurance. My Synergy physical therapy staff was responsible for explaining why certain services are considered non-covered by my insurance. In some case I might be requested to sign a financial liability form prior to non-covered services being rendered.

**If no payment is received or arrangements made, Synergy Manual Physical Therapy will automatically charge the card on file after 30 days for the statement balance.**

If a credit balance should ensue, our policy is to credit the stored card with the overpayment amount.

_____By entering my email address below, I am giving Synergy Manual Physical Therapy permission to send non-encrypted communication to me via email. My email address is:
_____.

_____ I prefer that communication between me, and Synergy Manual Physical Therapy be mailed via USPS. My mailing address is:
_____.

**NOTE:** I understand that while general communication over the internet between me and Synergy Manual Physical Therapy is not encrypted my actual credit card data is secured and cannot be viewed or accessed by our organization or external parties other than my banking institution. Our credit card system is registered with Visa and MasterCard and independently certified as a PCI-DSS Level One Service Provider.

**Patient's Printed Name: _____**

**Patient's Signature: _____Date: _____**