SYNERGY
Physical Therapy and Yoga Inc.

Name _____ SS# _____

Address _____ City_____Zip _____

Home Phone _____ Work Phone _____

DOB _____Marital Status_____Age____Occupation_____

Insurance Information

Is your injury: ○Work Related ○ Auto Related ○ Other Date of injury/Surgery _____

Primary Insurance_____Insurance Phone#_____

Responsible party: ○Self ○Spouse ○Guardian ○Other

Adjuster _____ Insured Name _____
Claim/Policy # _____ Group Name _____
Secondary Insurance _____

Consent to treat: I authorize Synergy Physical Therapy & Yoga, Inc. to render services as deemed necessary for the care of the above named patient. YES○ NO○ ____ (Initial)

Medical Release of Information: I authorize Synergy Physical Therapy & Yoga, Inc. to release any medical information necessary to process this claim. Synergy may also obtain medical records and share information with your Physician in order to optimize and manage your health care. YES○ NO○ ____ (Initial)

I authorize the use of e-mails to notify me of upcoming appointments. In the event that we need to contact you by phone, may we leave a voice mail message? Your preferred Phone number _____. YES○NO○ ____ (Initial)

Assignment of Benefits: I understand that SPT will submit bills to my insurance company and I also understand that upon acceptance of services from SPT, I am responsible for any copays, deductible, co-insurance or any other balance not covered by my insurance. I agree to be held responsible for any cost incurred regarding collection of any unpaid balance for services rendered. I understand copays are to be paid at the time of service. ____ (Initial)

Cancellation Policy
We ask that you please be respectful of time scheduled for your appointment. Our policy requires a minimum 24 hour notice for a cancellation. Less than a 24 hour notice will result in a $35.00 charge for the first time, and a $70.00 charge the second time. This is not covered by your insurance policy and is your responsibility. _____ (Initial)

For your convenience, we accept Cash, Checks, Visa and MasterCard.

Patient Signature _____Staff Init. _____Date _____

Email:_____ (We use this to send appointment reminders and/or exercise programs.)

We publish a montly newsletter with information about our clinic, healthy tips and fun health related facts. Please check this box if you would like to receive this newsletter. You may unsubscribe at any time.