2919 Welborn St.,
Suite 100, Dallas, TX 75219
Phone: 214-579-9781 Fax: 214-579-9673

Patient Information Form

Please fill out this form completely and bring to your first appointment.

Full name: ____ Date:________________

Address:__________________________ City:___________ State:____ Zip:____________

Age:_______ Date of Birth: ___________ Male:_____ Female:______

Social Security Number:____NA___________ Email Address:_____________________________

Cell Phone:_______________ Work Phone:______________ Home Phone:________________

Preferred Method of contact: (circle) Cell / home / work /email / text

Employer:____________________________ Occupation:____________________________

Emergency Contact:_________________Relationship:________ Emergency Phone:__________

INSURANCE INFORMATION	DO YOU HAVE HEALTH INSURANCE? Y/N
Primary Insurance:	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder’s Name:	Policy Holder’s Name:
Relationship to Patient:	Relationship to Patient:
Group number:	Group number:
ID number:	ID number:
Please have Insurance card and drivers license available for copy	

By Signing below, I, attest that all the above information is correct and I authorize Synergy Physical Therapy and Pilates, LLC to use this information to verify benefits from insurance companies as deemed necessary for payment of treatment rendered.

Signed:____________________________ Printed Name:_______________________ Date:_______

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PHYSICAL THERAPY AND PILATES

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CONSENT FORM/RELEASE OF INFORMATION/COMPANY POLICIES

Patient Name ____________________________

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.

RELEASE OF INFORMATION

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.

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.

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.

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If the undersigned is covered by an out-of-network insurance provider, the following amount $__________will be paid to Synergy Physical Therapy and Pilates, LLC upon the date of service and will not be responsible for any other amount billed.

CANCELLATION POLICY

The undersigned is aware and agrees, whether signing as an agent or patient, to an out of pocket fee of $100 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 of 18, guardian signature of consent is required.

OUT OF NETWORK FILING

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 claims provided on a monthly basis, please make request in writing

____ _______________________

Signature of Patient/ Guardian or Responsible Party Date

____ _______________________

Printed name of Patient or Guardian Date

____ _______________________