SYNERGY PHYSICAL THERAPY

Patient Intake and Consent Form

Patient Information:

Last Name: _____First Name: _____Middle Initial: _____

Home Address: _____ Home Phone Number: _____

_____Cell/Work Number: _____

Age: ___ Date of Birth: ____/____/_____ SSN#: _____-_____-_____ Marital Status: S M D W Gender: M F

Email Address: _____

Emergency Contact: _____ Home Number: _____

Relationship to Contact: _____Alternate Number: _____

Primary Insurance:

Policy Holder Name: _____

Policy Holder's DOB: _____

Insurance Name: _____

ID #: _____

Secondary Insurance:

Policy Holder Name: _____

Policy Holder's DOB: _____

Insurance Name: _____

ID #: _____

Worker's Compensation/ Motor Vehicle Information:

Auto/WC Insurance: _____ Claim #: _____

Adjuster: _____ Adjuster Phone #: _____

Date of accident/injury: _____ Employer: _____

Employer Address: _____ Employer Phone #: _____

Consent: (Please initial at each line)

_____ **Consent to Treatment:** I consent to rehabilitation and related services at Synergy PT. In doing so I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/ or direct contact of a sensitive nature including but not limited to areas of my body I may consider sensitive and/or private.

_____ **Liability:** I know and agree that Synergy PT is not responsible for loss or damage to personal valuables.

_____ **Waiver & Release:** I herby release, discharge, and acquit Synergy PT, its agents, representatives, affiliates, employees, or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician, physical or urgent care services.

_____ **Authorization of payment**: I herby assign all benefits directly to Synergy PT and also authorize release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financial responsible party does not pay for the services I receive, I will be financially responsible for payment.

_____ **Notice of Privacy**: I acknowledge receipt of Notice of Privacy Practices.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: _____ Today's Date: _____