



# SYNERGY PHYSICAL THERAPY

## PROVIDER 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.**

**Uses and Disclosures:** We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

**Your rights:** In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

**Our legal duty:** We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. 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 you disagree with a decision we made about access to 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 can provide you with the appropriate address upon request.

**Equality:** This Company is an equal opportunity provider and will not discriminate against patrons because of sex, religion, race, color, age, national origin, or disabilities.

**Chaperone Policy:** A patient or the patient's legal representative, such as a parent, guardian or surrogate, has the right to request a chaperone during the patient's examination or treatment. A care provider may request to have a chaperone present during the patient's examination or treatment.

If you have any questions, comments, or complaints, please contact:

Owner: Nicole Evans  
1710 W.W. Horizon Ridge Pkwy #110  
Henderson, NV 89012  
Phone: (702) 498-9217 Fax: (702) 489-9134



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Henderson, NV 89012  
Phone: 702-489-9217  
Fax: 702-489-9134

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Okay to leave messages? Yes No

**Employer Information:**

Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Suite #: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Insurance Information: \*\*If you are the policy holder, then skip this section\*\***

Insurance Carrier: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Secondary Insurance:

Insurance Carrier: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Other Contact Information: \_\_\_\_\_

.....  
\*It is understood by both the patient and Synergy Physical Therapy that any charges will be billed to medical insurance if the information is provided. If for any reason, the insurance denies charges (due to deductibles, coinsurances, or termination of coverage) then Synergy Physical Therapy will be willing to work with the patient to provide any financial arrangements feasible. The patient is fully responsible for any payments that are made directly to the patient from the insurance company, and any coinsurances or deductibles as stated by the insurance company, including copays if not made at the time of service.

Patient Name: \_\_\_\_\_ Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_

\*It is understood that physical therapy can be considered dangerous, unless under the supervision of a staff member. Synergy Physical Therapy holds no responsibility if the patient, friend of the patient, or family member seeks injury while on the premises of Synergy Physical Therapy. Synergy Physical Therapy is not financially responsible for any injuries that occur on the premises or on its equipment. It is understood that this document must be signed; no oral agreement can be arranged. Upon signing this portion, the patient also gives full consent for Synergy Physical Therapy to treat any and all injuries associated with this patient.

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations. I give the following individuals permission to receive copies and/or information about my medical history:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that my healthcare and the payment for my healthcare will not be affected by me signing this form. I understand that I may see and receive a copy of the information described on this form if I ask for it, and that I may also have a copy of this form after I sign it. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

## HISTORY AND PHYSICAL CONDITION INFORMATION

Answers to the following questions will assist the therapist in providing a safe and effective treatment program.

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referred by:

- Physician  Insurance Company  
 Friend  Other

Problem to be treated: \_\_\_\_\_

Have you had treatment for this problem before?

- YES  NO

If YES, state when: \_\_\_\_\_

Where did you receive treatment: \_\_\_\_\_

Have you had surgery associated with this problem?

- YES  NO

If YES, state when: \_\_\_\_\_

Have you ever had PT before for another problem?

- YES  NO

If YES, state area treated: \_\_\_\_\_

Are you pregnant?

- YES  NO

Are you currently taking any medications?

- YES  NO

If YES, please list all medications?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

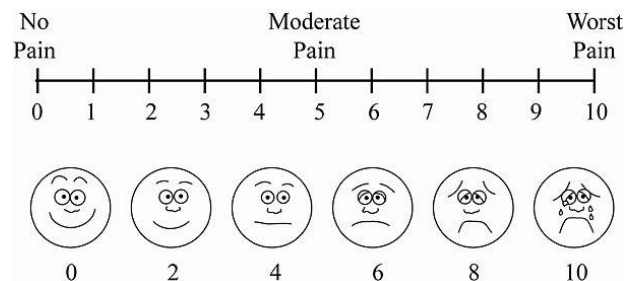
List any other major illness or surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you now have/ or have you ever had any of the following:

- High Blood Pressure  
 Heart Disease  
 Heart Attack  
 Pacemaker  
 Diabetes  
 Kidney Problems  
 Lung Disease  
 Cancer  
 Seizures  
 Neurological Disorders  
 Balance Problems  
 History of Falls  
 Sensitivity to Heat/Ice  
 Headaches  
 Dizzy Spells  
 Allergies  
 Hernia  
 Metal Implants  
 Vision Problems  
 Hearing Problems  
 HIV Positive/AIDS

### Current Pain Level



*The above information is correct to the best of my knowledge.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_