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. Horizon Ridge Pkwy #110
Henderson, NV 89012
Phone: (702) 489-9217 Fax: (702) 489-9134

SYNERGY PHYSICAL THERAPY

11201 S. Eastern Ave #220
Henderson, NV 89052
Phone: 702-614-0324
Fax: 702-341-0324

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: _____

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: _____

Authorization for Use or Disclosure of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising*

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:

☐ "Yes, I would like a copy of this form."
(Initialed by team member copy provided by: _____)

Practice Name: Synergy Physical Therapy

Patient Name: _____

Date: _____

Signature: _____

If Personal Representative

Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

If Patient is a Minor

Parent/Legal Guardiain: _____

Date: _____

Signature: _____

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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

Do you use any tobacco products?
□ YES □ NO

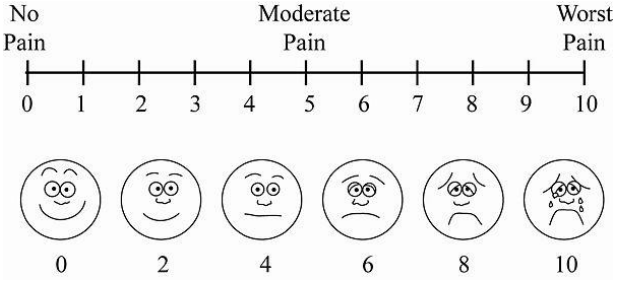
Are you currently taking any medications?
□ YES □ NO

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: _____