Synergy
Physical Therapy

CONSENT FOR CARE/TREATMENT AND DISCLOSURE AUTHORIZATION

Thank you for choosing **Synergy Physical Therapy.** Our mission is to provide you with superior therapeutic care in order to help you meet your rehabilitation goals. We ask that you **read** the statement below completely and **sign** if you are in agreement.

Consent for Care & Treatment: I, the undersigned, do hereby agree to give my consent to **Synergy Physical Therapy** to furnish medical care and treatment considered necessary and proper in treating my physical condition.

Benefit Assignment: I hereby assign all benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to **Synergy Physical Therapy**. A photocopy and/or scanned, electronic file of this assignment are to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Responsibility of Payment for Services: Synergy Physical Therapy verifies your health insurance coverage as a service to you. However, given the many variables within insurance plans, we cannot determine the specifics of your coverage or compel your insurance company to cover any specific treatment. We strongly recommend that you verify the specifics of your **coverage/benefits** with your health insurance provider. Please remember that you are responsible for all deductibles, co-payments, co-insurance amounts and any physical therapy visits not covered by your insurance. **I agree to pay a self-pay rate of $55.00 for any uncovered visit.** Your co-payments are due on the day that services are rendered and you will be billed for any missed payment. If your insurance company requires referrals or prior authorization, you must contact your **primary care physician** in addition to your referring physician before your initial evaluation.

Concerning Appointments: It remains your responsibility to attend and participate in all scheduled appointments. We have every expectation that you will reach your rehabilitation goals by attending your appointments and following the instructions of your therapist(s). Under all but extraordinary circumstances, we require a **24 hour notice in the event of a cancellation.** *If you fail to show up or do not cancel at least 24 hours prior to your scheduled appointment, you may be assessed a* ***$30.00 fee for the missed appointment.*** This fee is not covered by insurance plans and payment will be due upon your next visit. Three missed appointments may result in the discontinuation of your therapy. In this case, we will notify your physician of non-compliance and subsequent discharge. In this case, a new referral/script from your physician will be necessary to reinstate therapy. Please be aware that for **Worker's Compensation, Motor Vehicle Accident** and **Personal Injury** patients, any missed appointments may jeopardize your claim.

We may not be able to accommodate you if you are late for an appointment. We will do our best to see you if you are late, although this may result in an abbreviated treatment or seeing another therapist. If your appointment day/time is rescheduled, you may need to be seen by a therapist other than the one you normally see. However, all of our therapists are experienced, certified professionals who provide superior physical therapy.

Consent for Use and Disclosure of Protected Health Information: By signing this document you will permit the use, release and disclosure of your Personal Health Information (PHI) to carry out treatment, payment activity, health care options and obtain medical information related to your care. You may revoke or limit permission (in writing) for **Synergy Physical Therapy** to use and disclose your Personal Health Information (PHI) at any time. Revoking or limiting this permission, however, may affect our ability to adequately initiate or *continue treatment.*

Please complete the following if you are filing a claim under a ***Workers Compensation*** related injury:
Did the injury happen at work? □Yes □No
Have you reported your injury to your employer? □Yes □No
Your employer's contact person:_____Phone: ( )_____
Please complete the following if your are filing a claim under a ***Motor Vehicle Accident*** *related claim:*
Was the injury due to a motor vehicle accident: □Yes □No If yes, what type of accident? □ Auto □Motorcycle
Have you obtained an attorney? □Yes □No Attorney's Name_____
Phone: ( )_____Address:_____

I attest that this information is true and correct. I understand that if this information is NOT correct, I may be billed for services received through Synergy Physical Therapy.

X_____ _____ _____

Patient's Signature (or legal guardian if under 18 years) **Today's Date** **Patient's Date of Birth**