SYNERGY THERAPIES

INDIVIDUALIZED CARE • SUPERIOR RESULTS

Consent for Treatment, Information Release, HIPAA Privacy Notice

Patient Name: _____ Date: _____

CONSENT:

_____ *(please initial)* **-** I do hereby agree and give my consent for **Synergy Therapies** to furnish physical therapy treatment. Benefits, risks, and potential alternatives have been discussed to my satisfaction.

Synergy Therapies has my permission to allow students to observe my treatment and care.
Yes No *(circle one)*

RELEASE OF INFORMATION: As a condition of providing treatment to you, **Synergy Therapies** must obtain your consent to use and disclose protected health information about you to carry out treatment, obtain payment and health care operations of our office. This policy is to protect the patient and to also protect our staff from violating the patient's confidentiality. You may revoke this consent at any time by notifying the office in writing, except to the extent the office has taken action and reliance upon your consent. You have the right to request the office to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment or health care operations. The office is not required, however to agree to some requested restrictions.

I give consent to **Synergy Therapies** to release and or leave a message regarding treatment or appointments on the:
(Please initial all that apply)
_____: Answering machine at home
_____: Voicemail at work
_____: Cell phone number on file
_____: I **do not** consent to messages being left- contact me directly

PLEASE LIST BELOW ANY OTHER PERSON(S) WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS YOUR PHI and/or BILLING INFORMATION.
Name: _____ Relationship: _____ PHI: _____ Billing: _____
Name: _____ Relationship: _____ PHI: _____ Billing: _____

HIPAA PRIVACY NOTICE:

_____ (*Please initial*)**-** I acknowledge that I have received the HIPAA Privacy Notice and have had the opportunity to review its content.

**ARE YOU BEING TREATED AS A RESULT OF AN AUTO ACCIDENT: YES ____ NO ___
(If yes, have you supplied Synergy Therapies with your claim information?)

**ARE YOU BEING TREATED AS A RESULT OF A WORKERS COMP ACCIDENT: YES____ NO____
(If yes, have you supplied Synergy Therapies with your claim information?)

**ARE YOU BEING TREATED AS A RESULT OF AN ACCIDENT OF ANY KIND: YES ____ NO _____

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Privacy Policy

Types of Personal Information Collected by Synergy Therapies

We collect a variety of personal information necessary to administer rehabilitation services. This information is provided by the patient and at times, the referring physician. Information includes, but is not limited to, social security number, demographic information, insurance information, dependent information, past medical history, and medical status. This information is limited to that which is necessary in order to administer rehabilitative care, provide information for billing purposes and meet regulatory requirements.

How Information is Protected

Synergy Therapies treats personal information securely and confidentially as directed by state and federal laws. Access to personal information is limited to only those persons who need to know. Synergy staff members are trained on the importance of safeguarding all patient information and must comply with our policies and procedures, and the applicable law. Synergy Therapies meets strict physical, electronic, and procedural security standards to ensure protection of personal information and maintain internal procedures to promote the integrity and accuracy of all patient information.

Disclosure of Patient Information

Synergy Therapies may share any of the personal information collected as permitted by law. Synergy Therapies may also disclose this information to non-affiliated entities or individuals as permitted or required by law. Non-affiliates with whom we may disclose information as permitted by law include attorneys, accountants and auditors, health care providers, third party administrators, insurance carriers, and law enforcement or regulatory authorities.

Individual Rights to Access and Correct Personal Information

Synergy Therapies provides procedures for patients to access the personal information collected in connection with, or in anticipation of, a lawsuit or legal claim. Synergy Therapies will make this information available to patient following written request. Synergy Therapies goal is to keep patient information up to date and correct information on a timely basis. If you believe that any personal information needs updating or is inaccurate, please contact our office at:

19049 E Valley View Pkwy, Ste H
Independence, MO 64055
816-795-8944

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Patient Health Information

Name: _____ Date: _____

Please describe your current complaint or limitation: _____

Did you have surgery: Yes / No *If yes please list date of surgery:* _____

Please check current/past medical history that applies

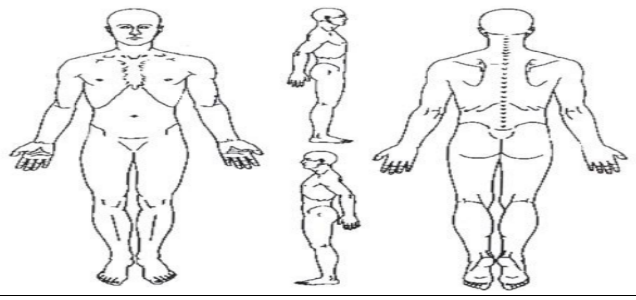
Heart Condition:		*Active Infection affecting any body region	
High Blood Pressure		*Blood Clot	
Stroke		*Transmittable Disease:	
Neurologic Condition/Disease		*Seizures: Controlled / Uncontrolled	
Osteoarthritis		*Incontinence: Bowel / Bladder	
Rheumatoid Arthritis		Fibromyalgia	
Osteoporosis		*Skin Disease:	
Diabetes: Type 1 / Type II		Cancer	
Bowel or Bladder Dysfunction		*Currently Pregnant	
Metal Implants/Joint Replacement		Dizziness/Fainting	
Psychological Condition		Decreased pulmonary function/Asthma	
Sexual Dysfunction		Other:	
Surgical History:			

**Starred items may affect your ability to begin aquatic specific therapies*

Are your symptoms (check one):	Worsening	The same	Improving
Have you had previous treatment for this condition?	Yes	No	

If yes, who did you see for this condition? MD Chiropractor PT OT Other: _____

Nature of Symptoms	
Sharp	Tingling
Dull Ache	Constant (76-100%)
Throbbing	Frequent (51-75%)
Shooting	Occasional (26-50%)
Burning	Intermittent (25% or less)



I have reviewed with the patient their rehabilitation potential prior to initiating treatment.

_____ _____

Patient/Guardian Signature Date Therapist Signature Date

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Patient Medication List

Name: _____

Medication	Dosage

Please initial if you are not currently taking medication(s) at this time: _____

_____ _____

Patient Signature Date

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Compliance, Cancellation/No Show Policy

The staff at Synergy Therapies is pleased you have chosen to have your therapy with us. We welcome the opportunity to provide you excellent care to assist you in the healing process, and we will do our best to meet your expectations.

In return we ask that you agree to the following:

- Make therapy a priority:
  - Scheduling appointments that coordinate your schedule with our availability is often a very difficult task, so we ask you to please remain flexible so that we may accommodate your rehabilitative needs.
  - Comply with the recommendations and home exercise program provided by your therapist
- Inform your therapist in advance when you are returning to your physician for follow up so that reports may be sent in a timely manner
- Understand that it is our goal to keep you with one to three therapists during your treatment duration. Schedule conflicts, vacations, etc. dictate treatment availability, so please be flexible
- If you need to reschedule your appointment, please call 816-795-8944 at your earliest convenience so that, if needed, another patient may be treated
- You may be discharged if:
  - Scheduled appointments are routinely cancelled
  - You No Show for (2) consecutive appointments without calling
  - You Cancel (3) or more appointments with reason at the discretion of the therapist
    - Physical therapists have the right to discharge a patient and inform the referring physician of multiple missed appointments by the patient, which will result in the cancelling of remaining appointments scheduled.
- Cancellation/No Show Fees
  - Same day cancellation: A $25 cancellation fee will be assessed for cancellation within 24 hours of your next appointment (*2 courtesy cancellations will be given to each patient, and charges will occur on the 3rd cancellation that is documented not more than 24 hours from appointment time)*
  - No Show: $25 no show fee
- Appointment Reminders: We have an automated call or text reminder. If you would like us to send you reminders, please let us know how you would like to receive the reminder: **Text** **Call** *(circle one)*

Please sign and date to indicate you have read and understand our patient compliance and cancellation/no show policy.

Signature: _____ Date: _____

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Patient Assignment of Benefits

Your therapist will discuss the items below as related to your care and recovery during your evaluation. If you have any additional questions, please consult with your therapist regarding your questions and concerns, then sign below when items have been discussed to your agreement.

1. Treatment without discrimination as to age, race, color, religion, sex, national origin, political belief, or handicap. It is our intention to treat each patient as a unique individual with recognition to basic human rights.
2. A description of the treatment ordered or recommended was explained to me.
3. Risks and benefits of treatment were explained.
4. Risks and benefits of going without treatment were explained.
5. Possible alternatives to the recommended treatment were discussed.
6. The initial treatment plan may need to be changed or additional treatment may be ordered upon physician approval.
7. Billing policies have been discussed with me.
8. My questions regarding my care and treatment plan have been answered.
9. I hereby authorize Synergy Therapies to carry out all procedures as ordered by my physician.
10. I authorize direct payment of benefits to be made on my behalf to Synergy Therapies. I understand and agree that I am ultimately responsible for all fees, regardless of my insurance coverage.
11. I consent to the release of my medical records by Synergy Therapies for the purpose of review or audits to my doctor, insurance company, or adjustor.
12. A photocopy of this assignment shall be considered as effective and valid as the original.

The above items have been discussed with me, to my satisfaction, and I understand and consent to the planned therapy treatment.

_____ _____

Patient/Guardian Signature Date

_____

Therapist Signature

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Medicare Questionnaire

Patient Name:_____ Medicare ID#:_____

Please read each item below and respond to items that apply to your CURRENT situation.

1. If you have received Home Health Care of any kind in the past 60 days, please provide the name and phone number of the Home Health Agency (HHA).
   HHA Name:_____ Phone:_____
   Date of Discharge:_____

2. Are you or your spouse currently working full time or part-time?
   _____ Yes
   If yes please provide employers name and address as well as employee count with regard to staff < or > 20.
   Name, Address, Employees:_____
   _____ No
   If no please provide patient or spouse's date of retirement or termination of employer group medical coverage.
   _____

3. Are you covered under an employers group health plan based on your current employment or the current employment of your spouse?
   _____ Yes
   _____ No

4. Are you entitled to Medicare benefits due to disability?
   _____ Yes
   a. Does an employer group through either you or your spouse provide you with medical coverage also (excludes retirement plans)? _____Yes _____ No
   _____ No

5. If you are entitled to benefits under **Black Lung Program**, **Department of Veteran Affairs or other government program**, please provide the name, address and phone number of that program.

   Program Name:_____
   Address:_____
   City, State, & Zip:_____
   Phone:_____

This government program will be primary to Medicare

6. Was your illness/injury due to any of the following:

_____ Automobile Accident Date of Accident:_____
_____ Work Related Date of Accident:_____
_____ Accident on Property other than your own Date of Accident:_____

Description of accident including where it occurred:

_____

_____

Please provide the name, address, and contact information of the liability insurance.

Insurance Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Contact:_____

Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing Medicare.