Synergy Physical Therapy
Patient Intake Form

Patient Information:

First Name: _____Last Name_____

Sex_____Date of Birth_____SS#_____-_____-_____

Address_____City_____State_____

Zip Code_____Phone#_____-_____

Email:_____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

Employer's Name_____Occupation_____

Referring Physician's Name_____

Diagnosis_____

Emergency Contact: _____Relationship:_____

Phone#: ( ) _____-_____

Insurance Information:

Insurance Name_____Policy#_____

Copay: $_____Employer's name:_____

Subscriber's Name: _____ SS#:_____-_____-_____

Date of Birth:_____Address: _____

City: _____State: _____ Zip Code: _____

Patient's relationship with the subscriber:_____

The above information is true to the best of my knowledge. I hearby authorize my insurance benefits be paid directly to Synergy Physical Therapy. I also authorize Synergy physical therapy and my insurance company to release any information required to process the claims.

Patient's Signature:_____Date:_____

Synergy Physical Therapy

Patient Intake Form

Financial Liability:

Your health insurance plan is a contract between you and your insurance company. We are not a party to it. We will attempt to obtain payment from your insurance company but you are responsible for any and all charges not covered by your insurance company. By signing below you are acknowledging your responsibility for any uncovered services and charges.

Patient's signature: _____ Date:_____

Cancellation Policy:

Thank you for choosing Synergy Physical therapy**. Keeping up with your PT appointments helps you recover faster.** Your therapist has set aside 60 minutes just for you and it is important that you utilize that dedicated time. Therefore, cancellations/no shows are discouraged. **Please give us atleast 24 hours of cancellation notice. All late cancellations (less than 24 hours of notice) and all no shows will be charged $60 for missed treatment session.** Cancellation/ no show fee is not covered by insurance and must be paid before any future services are rendered.

I understand the cancellation/no show policy and acknowledge my responsibility to plan appointments accordingly.

Patient's signature_____ Date:_____