12012 E Mission Ave
Spokane Valley, WA 99206
(509) 413-1630
Fax: (509) 413-1673
www.synergyspokane.com

L&I Patient Information

Name: _____ Date: _____

SS#(optional): _____ Birth Date: _____ ☐ Female ☐ Male ☐ Married ☐ Single

Contact Information: _____ _____ _____
Home# Work# Cell#

E-mail Address_____

Preferred Reminder Method: ☐Call ☐Text ☐Email

Address: _____
Street Apt# City State Zip

Current Place of Employment:_____

Address: _____
Street City State Zip

Date of Injury: _____ L&I Claim # _____

Place of Employment When Injured: _____

Address: _____
Street City State Zip

Claims Manager's Name: _____ Phone #: _____

Visits used on this claim: PT_____ OT_____ MT_____

Person Responsible for Account – please check one: ☐ Self ☐ Guardian ☐ Spouse ☐ Parent

Emergency Contact

Name: _____

Telephone #: _____

Name: _____

Telephone #:_____

I authorize Synergy to discuss my account with the following people:

_____

_____

How did you hear about us?

☐ Friend/Family: _____

☐ I'm a returning patient

☐ Fair/Expo: _____

☐ Website ☐ Internet Search

☐ Phonebook ☐ Drive by

☐ Physician ☐ TV

☐ Insurance company:

_____

Back Up Medical Insurance Information

Primary Insurance

_____
(Subscriber) Last First MI

_____
Street City State/Zip

_____
Home # Work # Fax #

_____
Birth date (mo/day/year) Relationship to Patient

_____
Employer Insurance Co. & Phone #

_____
SS# Subscriber # Group #

Secondary Insurance

_____
(Subscriber) Last First MI

_____
Street City State/Zip

_____
Home # Work # Fax #

_____
Birth date (mo/day/year) Relationship to Patient

_____
Employer Insurance Co. & Phone #

_____
SS# Subscriber # Group #

Patient Agreements:

I understand that Synergy Healthcare does their best to work within the confines of L&I requirements, however I am responsible for keeping track of the details of my claim including: required referrals or prescriptions, insurance authorizations, and benefit limits.
I authorize L&I to make payments directly to Synergy Healthcare Inc.

I grant release of my medical history and other information about my treatment to third party payers and other health professionals.

I understand that if L&I does not cover the billed amount I am responsible for the unpaid balance. I understand that if I have an unpaid balance with Synergy Healthcare a minimum monthly finance charge will be applied of $2.00 up to 1% of my end of the month balance. In case of default payment I am responsible for any legal interest, collection costs and reasonable attorney's fees. There is a $25.00 return check fee on all unpaid checks to Synergy Healthcare.

The information on the patient information page and medical history is correct to the best of my knowledge.
I request and consent to receive treatment at Synergy Healthcare Inc.

I understand that my health is important and will take necessary steps to improve it under the guidance of Synergy Healthcare's highly trained therapists.

Appointment Cancellation and No-Show Policy:

I understand that Synergy Healthcare requires 24 hours notice prior to cancelling my appointment. If you do not give us 24-hours notice before cancelling an appointment or simply don't show up, it will be counted it as a no-show If I do not comply with this policy or no-show for my appointment. I understand that three no shows will result in immediate discharge from the program. Discharge due to absence will be reported to my physician and may result in a discontinuation of worker's compensation benefits.

When you don't show as scheduled, three people are hurt: 1) You, because you don't get the treatment you need as prescribed by the doctor and/or PT. 2) The therapist who now has an un-paid space in their schedule because the time was reserved for you personally; and 3) Another patient who could have been scheduled for treatment if you had given proper notice.

Notice of Privacy Practices Acknowledgement:

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that your *Notice of Privacy Practices* has been made available to me, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature_____ **Date**_____

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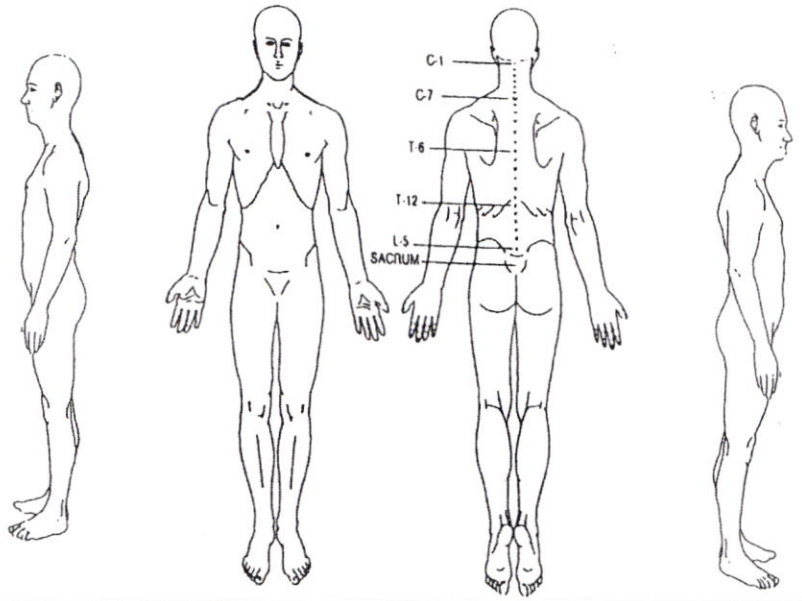
Medical History

Patient Name: _____ **Date:** _____

Primary Care Physician: _____ City/State: _____ Phone #: _____
Primary Complaint or Problem: _____
Date of Injury:_____ Have you had surgery for this injury? Y N Date:_____
Please describe how you injured yourself: _____
_____
_____

Do any of these cause you pain? (check all that apply)

☐ Sleeping	☐ Dressing	☐ Vacuuming	☐ Showering	☐ Putting on shoes/socks
☐ Standing	☐ Carrying objects	☐ Running	☐ Walking	☐ Going up/down stairs
☐ Sitting	☐ Driving	☐ Working	☐ Lifting	☐ Reaching overhead



Please Mark on the Bodies Where You Feel Pain, Tightness, Numbness or Tingling. (Use circles, lines, x's, etc.)

Rate Your Pain 0-10

☐Worst:_____
☐Current: _____
☐Best: _____

Current Symptoms:

_____
_____
_____
_____
_____

Have you had Past History or Difficulty with any of the following? (please check all that apply)		
☐Dizziness	☐Impingement Syndrome	☐Meniscal problems (torn, thin, etc)
☐Earaches, tinnitus (ringing)	☐Lateral Epicondylitis (tennis elbow)	☐Arthritis
☐Acid reflux	☐Sciatica	☐Osteoporosis
☐Headaches: Tension or Migraine	☐Leg Length Discrepancy	☐Asthma
☐Sinus Problems	☐Plantar Fasciitis	☐Autoimmune Problems
☐TMJ	☐Orthotics/Heel lifts	☐Cancer
☐Carpal Tunnel Syndrome	☐Allergies	☐Kidney Dysfunction
☐Diabetes	☐Fibromyalgia	☐Chronic Fatigue Syndrome
☐Hypo or Hyper Thyroid	☐Bipolar Affective Disorder	☐Depression
☐Stress	☐Sleep Difficulties	☐Skin Problems
☐Circulation Problems	☐Irregular Heart Beat	☐Digestive/Continence Problems
☐Tooth pain/ Dental Problems	☐Self regulation/ emotional issues	☐Eating issues (coordination/texture)
☐Coordination Issues	☐Muscle Weakness	☐Other:_____

Please list all major events that happened during these stages in your life: (include dates)
(Ex: traumatic events, severe sickness, surgeries, fractures, car accidents, divorce, death, child birth/C-section, etc.)

Age 0-20: _____

_____

_____

_____

Age 20-40: _____

_____

_____

_____

Age 40-60: _____

_____

_____

_____

Age 60+ _____

_____

_____

_____

What have you tried for relief?

☐ Home Remedies: _____ Successful: Y N
☐ Other Doctors: _____ Successful: Y N
☐ Physical Therapy: _____ Successful: Y N
☐ Massage Therapy: _____ Successful: Y N
☐ Acupuncture: _____ Successful : Y N
☐ Naturopathy: _____ Successful: Y N
☐ Chiropractic: _____ Successful: Y N
☐ Other: _____ Successful: Y N

What medications are you taking? (prescription, over the counter, vitamins, herbals or no medication)

_____

_____

_____

Do you have digestive issues? (allergies, upset stomach, improper digestion of certain foods, etc)

_____

_____

_____

Please list your goals for therapy- what activities would you like to be able to do again without pain?

_____

_____

_____

Current Exercise: _____

Nutrition: _____

Water Intake: _____ Sugar Intake: _____

Caffeine Intake: _____ Do you smoke? _____

Is there any other information you think will be of assistance to us in serving you better?

_____

_____

_____

_____