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

Motor Vehicle Accident (MVA) 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: _____

Date of Accident: _____ PIP Claim # _____

Claims Manager's Name: _____ Phone #: _____

PIP Benefit: $_____ Current Balance: $_____

Please list all services billed to this claim (ER visits, doctors visits, physical, occupational, massage therapy, etc.):

_____

_____

_____

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

Emergency Contact	**How did you hear about us?**
Name: _____	☐ Friend/Family: _____
Telephone #: _____	☐ I'm a returning patient
Name: _____	☐ Fair/Expo: _____
Telephone #: _____	☐ Website ☐ Internet Search
I authorize Synergy to discuss my account with the following people:	☐ Phonebook ☐ Drive by
_____	☐ Physician ☐ TV
_____	☐ Insurance company: _____

Back Up Medical Insurance Information

Primary Insurance	**Secondary Insurance**
_____	_____
(Subscriber) Last First MI	(Subscriber) Last First MI
_____	_____
Street City State/Zip	Street City State/Zip
_____	_____
Home # Work # Fax #	Home # Work # Fax #
_____	_____
Birth date (mo/day/year) Relationship to Patient	Birth date (mo/day/year) Relationship to Patient
_____	_____
Employer Insurance Co. & Phone #	Employer Insurance Co. & Phone #
_____	_____
SS# Subscriber # Group #	SS# Subscriber # Group #

Patient Agreements:

I understand that Synergy Healthcare does their best to work within the confines of my insurance plan, 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 my insurance plan 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 my insurance doesn't 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 I do not comply with this policy or no-show for my appointment I am responsible for the $50.00 no-show fee. I understand that three no shows will result in immediate discharge from the program. Discharge due to absence will be reported to my physician.

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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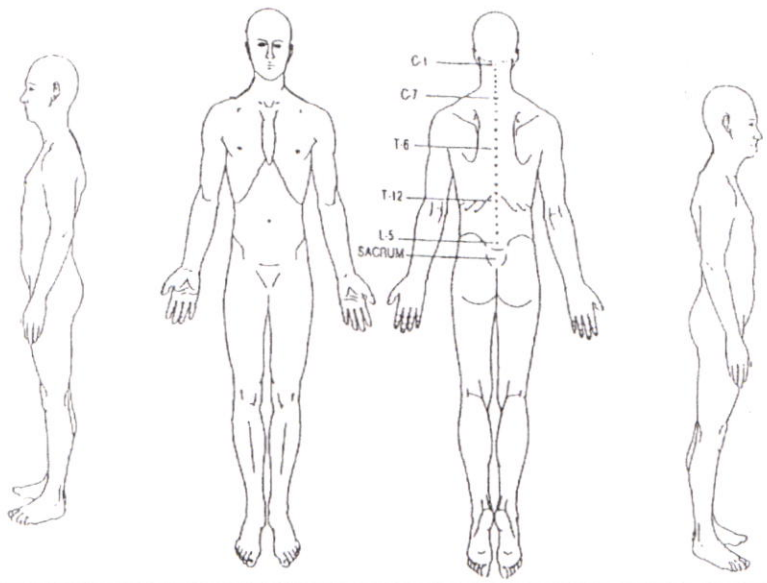
Medical History

Patient Name: _____ **Date:** _____

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

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?

_____

_____

_____

_____