SYNERGY PT
& ATHLETIC PERFORMANCE

4720 Puddledock Rd. Suite 130
Prince George, VA 23875
P: 804-520-7779 F: 866-463-3047

Please provide the following information. Please note: information you provide here is protected as confidential information

Patient Name: _____
(last) (first) (MI) (nickname)
Sex: M/F Marital Status: M S D W Date of Birth: _____ Age: _____
Mailing Address: _____ City: _____State: _____ Zip: _____
Cell Phone #: _____ Home Phone #: _____ Email: _____
Employer Name _____ Occupation:_____
Referring Physician: _____ Practice Name: _____
Emergency Contact/Relation: _____ Phone #: _____

Are you receiving or have you received home health services? Yes No
Are you receiving or have you received other therapy services? Yes No
Hobbies/Leisure Activities: _____

MEDICAL HISTORY:

Alzheimer's/Dementia	YES	NO	History of Cancer	YES	NO
Heart Disease	YES	NO	Immunosuppression	YES	NO
Stroke	YES	NO	Obesity	YES	NO
Current Infection	YES	NO	Osteoarthritis	YES	NO
Diabetes Type 1/Type 2 (circle one)	YES	NO	Parkinson's Disease	YES	NO
Fibromyalgia	YES	NO	Rheumatoid Arthritis	YES	NO
Fractures	YES	NO	Traumatic Brain Injury	YES	NO
High Blood Pressure	YES	NO	Headaches/ Migraines	YES	NO
Seizures	YES	NO	Allergies	YES	NO
Arthritis	YES	NO	Other:		

If you answered yes to any of the above please elaborate and include any conditions for which you have received medical treatment: _____
_____

Please list any past Surgeries and dates: _____

Please provide a complete list of all current medications and supplements including: Name, Dosage, Frequency and Route. Please use back page if needed. _____
_____
_____

Have you had any falls recently? Yes No Height: _____
If yes, describe: _____ Weight: _____

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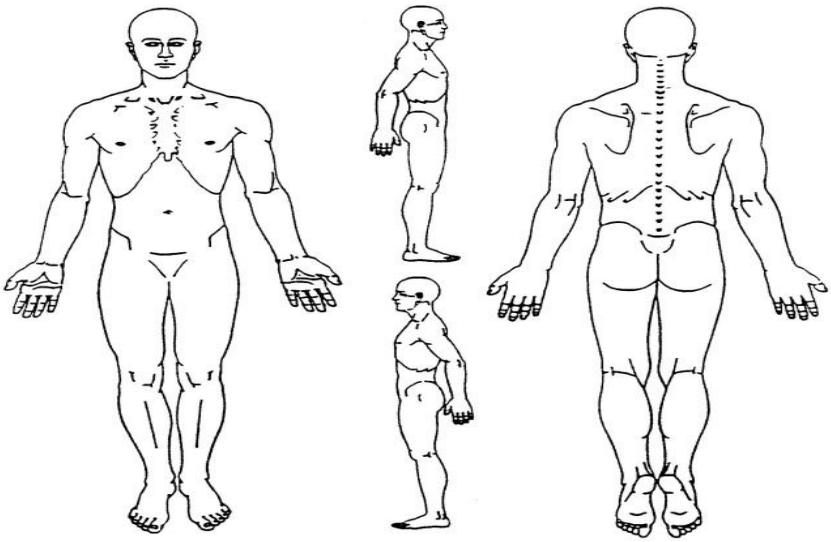
Please provide the following information. Please note: information you provide here is protected as confidential information

Date of injury:_____ How were you injured:_____

_____

Please shade all areas of pain or numbness.



Intensity: On a scale of 0 to 10 (0 being no pain and 10 being severe), circle the number that best describes your pain.

At Best: 0 1 2 3 4 5 6 7 8 9 10

At Worst: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

Describe pain: Sharp Dull Ache Burn Tingle Numb

Pain is made worse by: Sitting Lying Prolonged standing Bending Stairs When first arising
As the day goes on Other _____

Pain is made better by: Sitting Lying Prolonged standing Bending Stairs When first arising
As the day goes on Other _____

Serious illnesses or conditions: _____

When? _____

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Consent for Treatment

I hereby consent to evaluation and treatment by Synergy PT & Athletic Performance as ordered by my physician(s)/under VA Direct Access. I authorize the release of information related to my treatment to my physician(s).

□ I acknowledge receipt or have been offered a copy of the Privacy Practices from Synergy PT & Athletic Performance.

Patient's Signature: _____Date: ____/____/_____

Financial Responsibility

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I authorize my health insurance company to make payment directly to Synergy PT & Athletic Performance for any physical therapy services I receive. I am aware that benefits provided by my insurance are not a guarantee of payment and that ***I am ultimately responsible for all charges incurred during treatment***. I agree to pay my deductible, coinsurance, copayment, and any charges not reimbursed by my insurance carrier. I authorize the release of any information relating to my treatment in order to process my insurance claims and facilitate payment of my account.

Patient's Signature: _____Date: ____/____/_____

Cancellation Policy

I also understand I will be responsible for a **$50 cancellation/no show fee** if I do not notify Synergy PT & Athletic Performance **24 hours** prior to cancelling/rescheduling my appointment. Accounts beyond 90 delinquencies will be sent to collections and any collection costs or attorney fees incurred will be the responsibility of the patient/guarantor.

Cell Phone #: _____ Email Address: _____

I have read and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____Date: ____/____/_____

Witness Signature: _____Date: ____/____/_____

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12 Visit Philosophy / Policy

It is our belief that our job is to provide effective and cost-efficient care. We believe that most non-surgical conditions can be resolved in a 12 visit / 30 day period of time. If your condition(s) requires physical therapy intervention past that point, we require input from a physician for additional medical screening / testing.

I have read and agree to the foregoing statement.

Patient's Signature: _____Date: ____/____/_____