Synergy Physical Therapy
Registration and Disclosure

Name: _____
SSN: _____ **DOB**: _____ **Gender**: M or F

Address: _____ **Apt #:** _____
City: _____ **State:** _____ **Zip Code:** _____
Home #: _____ **Cell #:** _____
Email: _____
(For appointment reminders and office communication only)

Emergency Contact: _____
Relationship: _____ **Contact #:** _____

Have you had any PT or Chiropractic Treatment this year? YES or NO
Have you had any Home Health Care in the last three months? YES or NO
If Yes, Please Explain: _____

Business Disclosures to Individual Involved in Patient's Care

There may be an occasion when it is necessary for an individual, family, friend, or family member who is directly involved with your care to call and speak to with a staff member or therapist. I authorize Synergy Physical Therapy to disclose my billing and or health information that is directly related to my current treatment to the individual listed below. Synergy Physical Therapy will have open communication with your insurance and referring physician office.

Please list those individuals below (example: wife, child, partner, parental):

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

_____ I DO NOT wish to have my insurance, billing, or health information disclosed to any person, whether directly involved in my care of treatment.

Please sign and date below:
Patient Name or Representative (Please Print): _____
Patient or Representative Signature: _____ **Date:** _____

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