Synapse Physical Therapy
Elevate Colorado, LLC.

ADMISSION FORM

MR Number:

PATIENT INFORMATION

Patient Name:_____ Date Injured: _____

Address:_____ SS#:_____ Marital Status: S M D W O

City:_____ State:_____ Zip:_____ Date of Birth: _____ Sex: M F

Home Ph#:_____ Work Ph#:_____ Cell Ph# _____

Employer Name:_____ Workers Comp: Y N

Employer Address:_____ Auto Accident: Y N If yes, what State? _____

City:_____ State:_____ Zip:_____ **Have you received physical therapy at other locations this year? Y N**

Email_____ **If so, how many visits have you had?** _____

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL ☐ SELF

Insured (**Responsible**) Party Name:_____ Relationship to Patient: _____

Address:_____ Date of Birth:_____ SS#: _____

City:_____ State:_____ Zip: _____

Home Ph#:_____ Work Ph#:_____ Employer Name: _____

PHYSICIAN INFORMATION

Referring MD:_____ Phone #:_____ Primary Care MD:_____ Return to MD:_____

INSURANCE INFORMATION

*If you are being seen for an injury related to **work comp** or an **automobile accident**, please give us the name of your workers compensation /automobile carrier instead of your primary personal medical*

Primary Insurance:_____ Phone: _____

Group #:_____ Subscriber/SS#: _____

Pt. Relation to insured: Self Spouse Child Other

Adjuster:_____ Claim #:_____

Is your case in litigation? Y N

Attorney's Name: _____

Do you have Secondary Insurance? Y N

Name: _____

How did you hear about Synapse Physical Therapy? *(check all that apply)*

Friend/Relative? Who?_____ Physician:_____ Insurance: _____

Impact member:_____ Yellow Pages:_____ Website:_____ Other: _____

I authorize the release of any private health information necessary to process this claim.

I, the undersigned agree, whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to Synapse Physical Therapy/Elevate Colorado, LLC **BASIC BENEFITS** and/or **MAJOR MEDICAL** (catastrophe) **BENEFITS** herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records.

I have read, understand and signed the Synapse Physical Therapy/Elevate Colorado, LLC Financial Policy on the back of this page.

Signed: _____ Dated: _____
Insured and/or Responsible Party

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my physical therapist, athletic trainer and/or physician, may be considered necessary or advisable while a patient at Synapse Physical Therapy. I also understand that Synapse Physical Therapy may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

Signed:_____ Dated: _____
Insured and/or Responsible Party

Synapse Physical Therapy
Elevate Colorado, LLC.

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OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

All patients must complete our *Information and Insurance Form* before seeing the therapist.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so, on a bi-weekly basis. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and Synapse PT. **It is ultimately your responsibility to see that your physical therapy bill is paid in full**. Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying Synapse PT within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5% will be assessed per month. In the event a check is returned for any reason, a $20.00 charge will be made to your account.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

If you receive payment made out to both Synapse PT and you, please endorse the check and forward to us.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

ADULT AND MINOR PATIENTS

Adult patients are responsible for full payment at the time of service. The parents (or guardians) of a minor are responsible for full payment of the minor's treatment.

MISSED APPOINTMENTS

Because we commonly have a waiting list, unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. The charge is $50.00 for missed appointments. Insurance does not pay this charge. You are responsible. Please help us serve you better by keeping scheduled appointments, or call us to cancel, in a timely manner to allow another patient to have your scheduled time.

I have read the *Financial Policy*. I understand and agree to this *Financial Policy*.

HIPAA

I acknowledge the receipt of Synapse Physical Therapy's *HIPAA NOTICE OF PRIVACY PRACTICES*.

Signed:_____ Dated: _____

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

☐ Yes ☐ No If Yes, person's name:_____ Relationship:_____