Patient Name:

Synergistic Physical Therapy

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent to Synergistic Physical Therapy PC to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating my physical and mental condition.

AUTHORIZATION OF BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize Synergistic Physical Therapy PC to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Synergistic Physical Therapy PC from my insurance carrier or third-party payer. If payment for services rendered by this office is made directly to me, I recognize my obligation to promptly remit payment to this office.

I agree to pay any applicable copayments at the time of service and coinsurance and/or deductibles as agreed between Synergistic Physical Therapy PC and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third-party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. I also understand that balances over 60 days will be subject to a 2.0% finance charge.

The above may not apply for those patients that are considered Workers' Compensation. However, I understand that if I claim Workers' Compensation benefits and am subsequently denied such benefits, I may be held responsible for the total amount of charges for services rendered to me.

I authorize Synergistic Physical Therapy PC, to release all information necessary, including medical records, to secure payment. A photocopy of this authorization is to be considered as valid as the original.

_____ Responsible Party Initials

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION ACKNOWLEDGEMENT FORM

I have had full opportunity to read the Synergistic Physical Therapy PC Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Synergistic Physical Therapy PC to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. I understand the terms of this notice may change with time and Synergistic Physical Therapy PC will always post the current notice at the clinic, on the website, and will have copies available for distribution.

_____ Responsible Party Initials

CANCELLATION POLICY AND REMINDER MESSAGES

I understand all NO-SHOW Appointments or Cancellations with less than 24-hours notice will be charged a $50.00 fee. I understand this office may also send out reminder messages (email, text, or phone) for upcoming appointments, and I have the option not to receive reminders by informing the front office.

_____ Responsible Party Initials

SIGNATURE FOR CONSENT

By my signature below, I acknowledge that I have read, understand, and agree to the terms and conditions contained in the above sections and agree to comply as stated.

_____	_____	_____
Patient / Responsible Party Signature	**Print Name**	**Date**

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer, Leizl Adolphi.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, and/or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Leizl Adolphi** at (703) 852-0997 **or email her at leizl@synergisticpt.com** for further information about the complaint process.

This notice was published and becomes effective on **01-01-2022.**