Registration Form

Full Name: ____ DATE OF BIRTH:________________
(First) (Middle) (Last)

Gender: ☐ Male ☐ Female __________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address____CITY:____________________STATE:______ZIP:_________________

Preferred: ☐ Home Phone:(____)_________________ ☐ Cell:(____)_________________ E-Mail:____________________

SSN:_______________________ Preferred Language:_________________________ Ethnicity- Hispanic ☐ Yes ☐ No

Preferred Communication for Reminders: ☐ Phone Call ☐ Text ☐ Email RACE:______________________________

EMPLOYER:_________________________________ Occupation:________________ Work Phone: (____)____________

☐ Full Time ☐ Part Time

	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insurance		
Subscriber Name & Date of Birth		
Subscriber Relationship to Patient		
Policy/Member ID #		
Group/Plan Number		

EMERGENCY CONTACTS:

Name:____________________________ Phone: (____)_____________________ Relationship:_____________________

Name:____________________________ Phone: (____)_____________________ Relationship:_____________________

Preferred Pharmacy:____ Phone: (____)_____________________

Please Sign Back

(209) 472-2300
(209) 472-2446
Admin@SynergyMedUs.com
1801 E March Lane
Stockton, CA 95210
SynergyMedUS.com

Your signature below is acknowledgement that all the information above is correct and that you have read the HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I ACKNOWLWDGE AND AGREE THAT:
I hereby authorize Synergy Med to release to my insurance company all information, which they may require concerning my illness for reimbursement of services provided. Your signature below acknowledges and agrees to the terms set forth in "Our Office Policy Regarding Medical Insurance." I hereby assign to and authorize payment directly to the above-named service provider of all the benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for all services rendered by the above-named provider. The authorization becomes effective immediately and shall remain in effect indefinitely unless revoked in writing.
Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at Synergy Med. This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.") The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals The Minor Procedures are performed by a physician or qualified midlevel provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.
Financial Agreement: The undersigned agrees, whether he/she signs this form as the patient or agent of the patient , that in consideration of the services rendered by Synergy Med he/she obligates him/herself to the account in accordance with the regular fees and terms, which are subject to change without notice. In the event this account is referred to collections, the patient or patient's agent shall pay reasonable attorney's fees and collection expenses.
I understand that if this or any other visit precedes the effective date of my coverage, that Synergy Med hold you responsible for any and all charges incurred. If coverage is terminated, you will be responsible for all charges.
Returned Checks: Synergy Med will charge a service fee of $35 and value of the check.
Appointments must be cancelled within 24 hours or a service fee of $40 will be added to your account balance.
Medications I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to the Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication. **Privacy, Individuals Involved In My Care**. I understand that, unless I request confidentiality, the privacy laws allow Synergy Med to communicate with family members or others who may be involved in my care. I agree that the providers can communicate with me in the presence of family members or others who come with me to my appointment. If I object, I will notify my provider and ask my family to leave when the provider is discussing care with me.
Communication: By providing a phone number or email address, you are consenting to being contacted via phone, email, text message communication methods, regarding your appointments, medical equipment, treatment, or billing information. In addition, your email will be used to invite you to join our secure portal. You may request limitations on the method or content of communication in writing.

Name of Patient or Representative (print): ____ Date:_____________________

Signature of Patient or Representative:______________________________________ Relationship to Patient:___________