Synergy Medical Patient Reexam

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

Thank You!

PART A

Name: _____ Phone: _____

Do you mind if we send text message reminders about appointments?: Y N

E-mail address: _____

Address: _____

Purpose of this appointment: _____

Is this the same problem you were originally under care for? ( ) Yes ( ) No

If yes, are there any additional symptoms? _____

Other doctors seen for this condition: _____

What medications or drugs are you taking? _____

PART B

Occupation: _____ Employer: _____

Employer's address: _____ Work Phone: _____

Spouse: _____ Spouse's Employer: _____

PART C

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of (16%).

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Date Signed: _____ Signature: _____

Health Insurance Coverage ( ) Yes ( ) No

_____

Company:

1. What is your major symptom? _____
2. If this is a recurrence, when was the first time you noticed this problem?_____

   How did it originally occur?_____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

   If yes, when and how? _____
3. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

   How long does it last? All Day _____ Few Hours _____ Minutes _____
4. Are there any other conditions or symptoms that may be related to your major symptom?

   Yes _____ No _____. If yes, describe _____

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____
5. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other _____
6. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____

   _____. If no, what have you tried to do that has not helped? _____

   _____
7. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

   Lifting _____ Twisting _____ Other _____
8. Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates _____

   _____
9. List any major accidents you have had other than those that might be mentioned above: _____

   _____
10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____. If yes, please explain _____

    _____
11. NO SYMPTOMS — EXTREME SYMPTOMS

    _____

    Place an "X" on the line above to indicate your level of problem.
12. Remarks: _____

    _____

    _____

    Please place an "X" on the line above to indicate your level of problem.
13. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____

Last DOS:_____

Current Function Scores:_____**TX Plan**_____

Doctor's Signature _____ Date _____

Revised 2/15/2022

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Synergy Medical, Doctor Charita Cooper, Doctor Patrick Cooper, and Alana Grabovich, CNP, and Lindsay West, CNP** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20_____

X_____ (SEAL)
(Patient Signature)

X_____(SEAL)
(signature of Guardian if applicable)

X_____
(please print patient name)

CONSENT TO TREAT

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read below and if you have any questions, please feel free to ask.

AUTHORIZATION TO GIVE MEDICAL CARE-CONSENT TO TREATMENT:

I hereby voluntarily consent to outpatient care from Synergy Medical encompassing routine diagnostic procedures, physical examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications prescribed by the providers (joint injections, PRP, trigger point injections, regenerative cell medicine). I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Synergy Medical's medical providers and staff, as is necessary in the medical staff's judgment. I understand that during the course of treatment, health care workers may be exposed to the patient's blood and/or body fluids increasing the risk of contracting Hepatitis B, Hepatitis C and/or HIV. In the event that exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the healthcare worker. I understand that this consent will be valid and will remain in effect as long as I attend the clinic. Please see below for potential risks and side effects.

- Injection: increased pain or discomfort, infection, allergic reactions, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, hematoma formation, collapsed lung, seizures, even remote risk of death or serious disability that exist with any surgical procedure.
- Blood Draw: increased pain or discomfort, infection, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, or hematoma formation.
- Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.
- Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.
- Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

Consent to Evaluate and Treat a Minor:

I, _____being the parent or legal guardian of _____, have read and fully understand the above terms and hereby grant permission for my child to receive treatment with Synergy Medical.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

[ ] No One [ ] Name/Relationship: _____ Phone: _____

May we leave messages regarding your personal healthcare information on an answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgment

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Patient Print Name: _____Signature: _____ Date: _____

Witness Name Print: _____ Signature:_____ Date:_____

Women Only:

To the best of my knowledge, **I am/am NOT** pregnant and (**give my permission/don't give my permission**) to x-ray me for diagnostic interpretation.

Synergy Medical
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(937)642-4400 (p) ~ (937)642-4443 (f)

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individuals and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need the record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified.

Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email, or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Patient/Guardian Signature:_____Date:_____

PHOTO/VIDEO RELEASE FORM

Permission to Use Photograph/Video

I grant Synergy Medical, its representatives and employees the right to take photographs of me and my property in connection with the above identified subject. I authorize Synergy Medical , its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Synergy Medical may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature_____

Printed Name_____

Address_____

Date_____

Signature, parent or guardian_____

(If under age 18)

Alana Grabovich, CNP ● Lindsay West, CNP ● Charita N.Cooper, DC CACCP ● Patrick S. Cooper, DC CCEP

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my primary care physician of my condition, treatment and expected/actual response to care at this office.

Patient/Guardian Signature:_____

Name (Please Print):_____

Primary Care Physician:_____

Physician's Address/Phone:_____

_____

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