PATIENT REGISTRATION

SYNERGY
REHABILITATION AND WELLNESS CENTER

Patient Information *(please print)*				
PATIENT NAME (last, first, middle)	SOCIAL SECURITY #	SEX: ☐ M ☐ F	DATE OF BIRTH	AGE
ADDRESS	CITY / STATE / ZIP CODE		RACE/ETHNICITY	
HOME PHONE # ( )	CELL PHONE # ( )	WORK PHONE # ( )	PRIMARY LANGUAGE	
MARITAL STATUS: ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED	EMAIL ADDRESS MAY WE CONTACT YOU BY EMAIL: ☐ YES ☐ NO			
EMPLOYER/OCCUPATION			EMPLOYMENT STATUS: ☐ PART-TIME ☐ FULL-TIME	
REFERRED TO CLINIC BY: ☐ PHYSICIAN ☐ FAMILY ☐ FRIEND ☐ CLOSE TO HOME/WORK ☐ INTERNET ☐ OTHER: ______________________________				

Emergency Contact			
NAME *(last, first, middle)*	RELATIONSHIP	HOME PHONE # ( )	WORK PHONE # ( )

Financial Guarantor (responsible party)			
NAME OF FINANCIAL GUARANTOR *(responsible party)*	SOCIAL SECURTIY #	SEX: ☐ M ☐ F	DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP CODE		RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER
HOME PHONE # ( )	CELL/WORK PHONE # ( )		
EMPLOYER	EMPLOYER ADDRESS		

Primary & Secondary Insurance				
PRIMARY INSURANCE NAME	SUBSCRIBER NAME		DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE:
SECONDARY INSURANCE NAME	SUBSCRIBER NAME		DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE:

I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.

Authorization for release of information
I authorize SYNERGY REHABILIATION AND WELLNESS CENTER to release any medical information necessary for purposes of administration, review, investigation, or evaluation of claim coverage and utilization of services.

Assignment of benefits and financial responsibility
I authorize the assignment of benefits payable to SYNERGY REHABILIATION AND WELLNESS CENTER and/or its designee for physician services and supplies by government and/or other private third-party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services. I understand this office does not guarantee that my insurance company will pay for treatment I receive from this practice. They will perform routine insurance billing procedures upon verification of coverage. However, if my claim is denied, I will be responsible for paying the full amount at that time. This office will not enter into a dispute with my insurance company over any claim, although they will provide the necessary documentation my insurance company requests to clarify any confusion or questions that may arise. This office will fully cooperate with the regulations and requests of my insurance company. I understand that it is ultimate my responsibility to resolve any type of dispute over payments made or not made by my insurance company. If I feel the “patient responsibility” portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company.

Authorization for additional fees
In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney’s fees, court costs, collection fees, interest, and any additional costs that this action may incur.

Authorization for treatment
I agree to any examination, treatment, and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

Acknowledgement of Receipt of Privacy Notice
By signing below, I agree that I have received a copy of the **Notice of Privacy Practices for Protected Health Information.**

X____|____________________

SIGNATURE (Parent or Legal Guardian, if minor) DATE