CONDITIONS AND INFORMED CONSENT FOR PHYSICAL/OCCUPATIONAL THERAPY TREATMENT AT SYNERGY THERAPEUTIC GROUP

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. I_____ acknowledge informed consent and the details it includes have been explained to me.

Please initial each line in front of each category and sign and date below

_____**Condition and treatment plan:** I acknowledge and understand that a Physical /Occupational therapist of Synergy Therapeutic group, has explained to me about my musculoskeletal condition and has developed or recommended the plan of care in accordance to my physician's recommendation. I further acknowledge that the purpose of the care, reasonable alternative forms of therapy, risks of the recommended and alternative care and the risks of foregoing this care have been fully explained to and understood by me. I agree to cooperate fully and to participate in all physical therapy care procedures, to comply with the plan of care as it is established and to pay Clinic's charges for such care upon my receipt of Clinic's invoice for such care.

_____**Potential benefits:** I acknowledge that the potential benefits of treatment have been explained to me. This may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

_____**Potential risks:** I acknowledge the potential risks in treatment have been explained to me. I understand I may experience a temporary increase in my current level of pain, discomfort, or an aggravation of my existing injury if I have one. My therapist has explained that this discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist. The risks of foregoing therapy and pursuing alternative forms of treatment have also been explained by my therapist.

_____ **Physical Contact:** I also recognize that Physical/Occupational therapy care may involve close physical contact and touching of my body by a Therapist or other members of the Clinic's professional staff. This person may be of the opposite sex, and that full or partial disrobing may be required to facilitate such care, all of which is expressly consented to by me.

_____**Warranty and Guarantee:** I recognize that the practice of Physical/Occupational therapy is as much an art as a science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any therapy. Like medical treatments, I understand my therapist will develop my treatment plan based on his or her educated and professional opinion and revise the treatment plan where necessary if the desired results are not being achieved.

_____**Alternatives and discontinuing Therapy :** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Assignment of Benefits to SYNERGY Therapeutic Group

Patient Name: _____
Insurance Policy #: _____
Insured Name: _____
Claim #: _____

I hereby instruct and direct _____insurance company to pay by check made out and mailed to:

SYNERGY Therapeutic Group

12 S Division St	1110 Cedar Court
Du Quoin, IL 62832	Carbondale, IL 62901
618-542-8950	618-529-4360

If my/this current policy prohibits direct payment to doctor I herby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ☐ A photocopy of this Assignment shall be considered as effective and valid and the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions
- ☐ I authorize SYNERGY Therapeutic Group to deposit checks made in my name.
- ☐ I authorize SYNERGY Therapeutic Group to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all changes whether or not paid by insurance.

Dated this _____day of_____, 20___.

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

SYNERGY THERAPEUTIC GROUP

FINANCIAL & INSURANCE PLAN POLICY

We take pride in the high-level quality of our services. You've made an excellent decision by choosing to resolve your pain and problem with us here. In order to provide you with the best possible care, please address the following policies:

- **Payment for services is due at the time services are rendered, unless other payment arrangements have been approved in advance by our staff.**
- **We accept cash and personal/business checks. Return check fee is $25.00, plus any additional bank fees. More than one returned check will result in patient being required to pay with cash or card only.**
- **Returned checks and balances over 30 days old will be subject to interest charges of 1.5% per month and any other applicable collection or attorney fees.**
- **A $60.00 charge will be assessed for "no call no show" appointments, meaning you do not come to your appointment and do not call our office to cancel or reschedule, prior to that appointment.**
- **A $25 charge will be assessed for appointments cancelled without 24- hour advance notice.**
- **A $15 charge will be assessed for appointments rescheduled without 24- hour advance notice.**
- **Patients with repeated cancellations and late reschedules may be removed from further appointments.**

We are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

- If you request, we will help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit.
- You may assign your insurance benefits and we will deal directly with your insurance company on your behalf.
- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:
    a. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
    b. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage such as 50% or 80% of "U.C.R." "U.C.R." is defined as usual, customary, and reasonable. (This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees which bears no relationship to the current standard and cost of care in this area).
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
If you have any questions about the above information or any uncertainty regarding your insurance coverage PLEASE don't hesitate to ask us. We are here to help you.

I have read and agree to the policies mentioned above.

Patient Name:_____

Patient Signature:_____ Date:_____
(Signature of Patient Parent/Legal Guardian)

Authorization to Use or Disclose Protected Health Information
SYNERGY Therapeutic Group

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, SYNERGY Therapeutic Group may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:
Referring Physician

Patient Health Information authorized to be disclosed:
Evaluation, Status Notes, Discharge Note, Patient's Results

For the specific purpose of (describe in detail)

Treatment as prescribed.

Effective dates for this authorization: ____/____/____ through ____/____/____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*

SYNERGY THERAPEUTIC GROUP
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.

SYNERGY THERAPEUTIC GROUP is required by law to provide you with this notice explaining our privacy practices with regard to your medical information and how we may use and disclose your **Protected Health Information.**

Ways in which we may use and disclose your Protected Health Information (PHI)

Treatment-We will use and disclose PHI about you to provide you with medical treatment or services, coordinate care, manage your health care and any related services. Examples include sharing information with your primary or ordering physician.

Payment- We will use and disclose your PHI to obtain payment for the therapy services we provide for you. For example, we may include information with a bill to a third- party payer that identifies you, your diagnosis and services performed. We may also talk to your health plan about a treatment you are going to receive to obtain prior approval or determine whether your plan will cover the treatment.

Worker's Compensation- We will disclose your PHI as necessary to comply with State Workers Compensation Laws.

Lawsuits and Disputes- If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other legal process from someone else involved in the dispute.

Minors- We will disclose PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Inmates- We will use and disclose your PHI to a correctional institute or law enforcement official only if you are an inmate of that correctional institution or under the custody of a law enforcement official. This would be necessary for the institution to provide you with therapy.

Law Enforcement- We may disclose you PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Emergencies- We will disclose your PHI to notify or assist in notifying a family member or another person responsible for your care about you medical condition or in the event of an emergency or death.

Public Health-As required by law we will disclose you PHI to public health authorities for purposes related to preventing or controlling disease ,injury or disability, reporting child abuse or neglect, domestic violence, reporting to the Food and Drug Administration (FDA)problems with products and reactions to medications and reporting disease or infection exposure.

Coroners, Medical Examiners and Funeral Directors- We may release PHI to a coroner, medical examiner or funeral director so they can carry out their duties.

Organ Donation and tissues. If you are an organ donor, we may release PHI to organizations that handle procuring, banking or transplanting organs

Research-We may use or disclose your PHI for research purposes, but we will only share after a special approval process.

Military, Veterans, National Security and Intelligence- If you are or were a member of the armed forces or part of the national security or intelligence communities, we may be required by military command or other government authorities to release PHI about you.

Marketing- We may contact you by email, newsletter, telephone or other correspondence respectfully, to inform you of any new information that will help you better continue your therapy with Synergy Therapeutic Group. It is not our policy to share any of your PHI to anyone during these times.

Change of Ownership- In the event that SYNERGY THERAPEUTIC GROUP is sold or merged with another organization your PHI will become property of the new owner.

Your Rights Regarding Your Protected Health Information (PHI)

- **You have the right to request restrictions on certain uses and disclosures of your PHI.**
- **You have a right to a copy of our medical records (administrative fees may apply)**
- **You have a right to get a notice of security breach**
- **You have a right to confidential communication**
- **You have a right to a paper copy of this notice**

Complaints

Complaints about your privacy rights, or how Synergy Therapeutic Group has handled your health information should be directed to Subrat Bahinipati by calling 618-529-4360. If he is unavailable, you may make an appointment for a personal conference in person on by telephone within two business days.

If you are still not satisfied you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in this notice.
By way of my signature, I provide Synergy Therapeutic Group with my authorization and consent to use and disclose my protected healthcare information for the purpose of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient's Name (print)	Patient's Signature or Parent/Legal Guardian
Date	Authorized Facility Signature
	Date

Synergy Therapeutic Group

Is your treatment related to a motor vehicle accident or a worker's compensation injury?

_____ yes _____ no

Print Patient's name_____ Date _____

Signature _____

(patient, parent/ guardian)

SYNERGY THERAPEUTIC GROUP

Patient Name: _____ Date: _____

Your therapy with **Synergy Therapeutic Group** is very important to us. For you to receive the best care possible please inform us if you are currently doing any of the following activities or practices.

Aquatics: Yes/No

Aerobics: Yes/No

Weight Training: Yes/No

Chiropractor: Yes/No

Acupuncture: Yes/No

Acupressure: Yes/No

Massage Therapy: Yes/No

Injections please specify the area and type of injections: _____

_____

Other forms of traditional or non-traditional therapies: _____

_____

Synergy Therapeutic Group

As a courtesy, our office will send you an automated reminder of your scheduled appointment date & time. **This service is a courtesy only, and cancellations/reschedules are not accepted through this system, although you may be given the option.** ***Please initial to confirm understanding*** _____

If you need to make any changes to your appointments, please contact the office directly. If you do not contact the office to make appointment changes at least 24 hours prior to your scheduled appointment, you will be subject to the appropriate fees associated with your cancellation/reschedule. If you are seen for both Physical and Occupational Therapy, please remember that you are reserved 2 appointment times, and you will receive 2 appointment reminders. You should always arrive on time for the earlier appointment time. **Again, if you need to make any changes to your scheduled appointment, always contact the office directly. Changes are not accepted through the automated appointment reminder system.** ***Please initial to confirm understanding*** _____

(Please select the method in which you would like to receive appointment reminders.)

____ Text cell phone

____ Call cell phone

____ Call home phone

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date