SYNERGY
Primary Care

# New Patient Intake Form

## Patient Info

Legal First Name: _____ Gender: _____ Sex at birth:_____
Legal Middle Name: _____ Social Security Number: _____
Legal Last Name: _____ Preferred Language: _____
Date of Birth (MM/DD/YYYY) : _____ Ethnicity:_____
Previous Name: _____
Primary Phone#: _____ ◯ Home ◯ Cell ◯ Work
Secondary Phone#: _____ ◯ Home ◯ Cell ◯ Work
Email: _____
Preferred Contact Method (check one): ◯ Text message ◯ E-mail ◯ Phone Call ◯ App message
Opt-out of all appointment reminders? Circle one: Yes / No
Patient Address: _____
City: _____State: _____ Zip Code: _____

## Emergency Contact

First Name:_____ Last Name:_____ Relationship:_____
Phone number:_____
Address:_____

**Financial Guarantor** (check one): ◯ Myself ◯ Others (fill out the followings if checking others)
Guarantor first name:_____ Last name:_____ Relationship: _____
Phone number:_____ Address: _____

## Insurance Information

◯ I do not intend to use insurance
Primary Insurance Carrier Name: _____ Plan Name:_____
Member ID: _____
Primary Insurance Policy Holder Name:_____
Relationship with patient: _____ Date of birth of policy holder: _____
Primary Insurance Policy Holder Address: _____

Secondary Insurance Carrier Name: _____ Plan Name:_____
Member ID: _____
Secondary Insurance Policy Holder Name:_____
Relationship with patient: _____ Date of birth of policy holder: _____
Secondary Insurance Policy Holder Address: _____

**Preferred Pharmacy**

Pharmacy Name: _____ Zip code: _____

**Past Medical History**

What medical conditions do or did you have? □ None

| | | | |
|---|---|---|---|
| □ Diabetes Type I | □ Diabetes Type II | □ High Blood Pressure/Hypertension | □ Hepatitis A |
| □ High Cholesterol | □ Heart Disease ** | □ History of Stroke | □ Hepatitis B |
| □ History of Heart Attack | □ Liver Disease ** | □ Pancreatitis | □ Hepatitis C |
| □ Kidney Disease | □ Breast Disease ** | □ Thyroid Disease ** | □ Migraines |
| □ Blood clots | □ Chronic Pain | □ Arthritis | □ Epilepsy |
| □ Osteoporosis | □ Autoimmune Disease** | □ Traumatic Brain Injury | □ Asthma |
| □ Sleep Apnea | □ Hearing Impairment | □ Pituitary Adenoma | □ COPD |
| □ Tuberculosis | □ Cancer ** | □ Alzheimer's or Dementia | □ Emphysema |
| □ HIV/AIDS | □ Fibroids | □ Endometriosis | □ PCOS |
| □ Sinusitis | □ Colon Polyps | □ Irritable Bowel Syndrome | □ Rhinitis |

**Asterisk above. Further details if checked:_____

Other medical conditions: _____

**Past Surgical History** □ No surgery in the past

| Year | Type of surgery / Complications | Location (Hospital, City, State) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Medications**

List all medications you are currently taking, including dose and frequency. (e.g. Amlodipine 5mg once a day)

**Allergies to medications or substances**

□ No known drug allergies □ Yes, allergic to: _____

**Health Maintenance**

If known, please list the most recent month and year occurred below. □ No known info available

| For women only | For both men and women | | For men only |
|---|---|---|---|
| Pap smear: | Bone Density (DEXA): | Flu shot: | PSA (prostate): |
| Mammogram: | Stool occult blood test: | TDAP: | |
| | Pneumococcal vaccine: | Colonoscopy: | |

**Habits**

Check the followings if appropriate. □ No such habits

| | | | |
|---|---|---|---|
| Cigarette smoking | □ Start year: | □ Cigarette per day: | □ Quite year: |
| Alcohol | □ How many drinks per week: | | |
| Recreational Drugs | □ drug name: | | |

**Family history** □ No known family history

| Relation | Medical condition |
|---|---|
| Father | |
| Mother | |
| Brothers | |
| | |
| | |
| Sisters | |
| | |
| | |
| Others | |
| | |
| | |

**Health Insurance Portability and Accountability Act (HIPAA) Patient Authorization**

Which method would you like to receive appointment information, lab or imaging results, or other communications from Synergy Primary Care? □ Email □ Phone □ Either or both

Phone: _____ Email Address: _____

Do you authorize Synergy Primary Care to release confidential information such as lab results, imaging results, appointment information, and other medical related information to the above contact? □ Yes

To give Synergy Primary Care permission to disclose your medical history with a person other than yourself, please fill out their contact information below. Otherwise, check here: □ No one other than myself

Full name: _____ Relationship: _____
Phone number: _____ Email: _____

The above authorization is valid for 1 year from the date of signature. The authorization will automatically renew for 1-year intervals upon expiration unless it is cancelled or changed by the patient.

**Signature**

By signing below, I certify that the information on this form is accurate to the best of my knowledge. I also agree with the HIPAA authorization above.

Patient signature: _____ Date: _____

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## Notice of Privacy Practices Acknowledgement

By signing below, I acknowledge I have received and reviewed the Notice of Privacy Practices and voluntarily consent to the use and disclosure of my protected health information for treatment, payment, and operations permitted under the Health Insurance Portability and Accountability Act (HIPAA). I understand I can find copies of the current notice available on www.synergypcp.com to review how my medical information can be used and disclosed.

## Consent to Receive Treatment

By signing below, I voluntarily consent to reasonable and necessary medical examinations, testing, treatment at Synergy Primary Care. I give permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). I understand that I have the right to refuse any medical services.

## Financial Responsibility Agreement

By signing below, I hereby authorize Synergy Primary Care to request payment from my insurance plan in regards to the services I received. As a courtesy, Synergy Primary Care will file claims on patients' behalf. However, if the insurance company fails to approve payment in **45 days**, I agree that I will become financially responsible for services rendered on my behalf for which a charge may be associated. I accept financial responsibility for all **cost-sharings, co-payments, deductibles, and non-covered services**, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me. By signing below, I elect to proceed with services with the understanding that I may be personally responsible to pay for the past, current and future services being rendered to me.

Payment is due at the time when services are rendered, and any remaining balances will be billed. I understand that any outstanding balances on my account after 60 days will be subject to a $50 charge added to the balance each month until the balance is paid in full. If my account becomes overdue, Synergy Primary Care may take necessary steps to collect the balance owed, which may include involving a collection agency and/or attorney. In such cases, I will be responsible for any associated collection fees such as attorney's fees, collection agency costs and any other fees related to my bill.

I agree that I must have a valid credit card, debit card or bank account information on file with Synergy Primary Care in order to receive any services. I authorize Synergy Primary Care to automatically charge the

credit card, debit card, or bank account on file for any outstanding balances. A statement or receipt will be provided after the charges are confirmed.

## Insurance Eligibility Check Agreement

While Synergy Primary Care can perform a preliminary eligibility check as a courtesy, **it does NOT provide a guarantee of payment from insurance companies**. I understand that **I am responsible for confirming and knowing my benefits or coverage, as well as any coverage limitations** with my health insurance plan. I understand that a service being "covered" does not always mean it is free of charge. If I prefer to utilize my in-network benefits, it is my responsibility to verify that Synergy Primary Care is in network with my insurance provider and to confirm whether my insurance plan will cover the charges associated with my visit. Therefore, I understand that I cannot assume my visit charges will be paid for by my insurance company. **If my insurance plan subsequently declines to cover fully the service I have received, I agree that I will take full financial responsibility.**

## Appointment Cancellation Agreement

Per Synergy Primary Care policy, all appointment cancellation/rescheduling requests must be submitted to the office and confirmed by office staff **more than 24 hours prior to** the scheduled date and time. By signing below, I agree that I will be held responsible for a **$100 cancellation fee if the appointment is canceled/rescheduled within 24 hours prior to the scheduled appointment.** I also agree that the fee will be automatically charged to the payment method on file if the above occurs. If the payment method fails to go through, I agree to pay for the cancellation/rescheduling fees with an updated method of payment within 60 days of the cancellation/rescheduling. If my account becomes overdue, Synergy Primary Care may take necessary steps to collect the balance owed, which may include involving a collection agency and/or attorney. In such cases, I will be responsible for any associated collection fees such as attorney's fees, collection agency costs and any other fees related to my bill.

I understand that there are no cancellation/rescheduling fees for requests made more than 24 hours prior to the scheduled date and time.

## Laboratory/Imaging Responsibility Statement

I understand that my insurance plan may NOT cover some tests that were ordered during my visits, in which case I will become financially responsible for the tests ordered and will receive bills from the laboratory or imaging center. Synergy Primary Care will bear no responsibility for the costs of these tests performed. Furthermore, I understand that it is my responsibility contact my insurance company to identify specific labs or imaging centers in network. It is also my responsibility to notify Synergy Primary Care of which lab or imaging center to use.

I certify that I have read and fully understand all of the above statements and consent fully and voluntarily to its contents. I further agree that a photocopy of this form shall be as valid as the original.

**Signature**

**I confirmed that I have thoroughly read through and agree with the information above.**
**(You must click all boxes to proceed.)**

◯ Notice of Privacy Practices Acknowledgement
◯ Consent to Receive Treatment
◯ Financial Responsibility Agreement
◯ Insurance Eligibility Check Agreement
◯ Appointment Cancellation Agreement
◯ Laboratory/Imaging Responsibility Statement

**You are signing as patient**: (Circle one) Yes / No

**If you are not signing as patient, please state your relationship with patient:**

**By signing below, I certify that I have read and fully understand all of the above statements and consent fully and voluntarily to its contents. I further agree that a photocopy of this form shall be as valid as the original.**

**Patient Name: _____**

**Patient Signature: _____**

**Date: _____**

## Credit Card Authorization Form

Synergy Primary Care requires that a credit card, debit card, or HSA card to be on file with our office for payment of any outstanding balance incurred from our services. Your credit card information will be kept confidential and secure, and payments to your card are processed only after the claim has been filed and processed by your insurance carrier if applicable.

Patient responsibility balances are outlined in the Explanation of Benefits (EOB) that will be mailed to you by your insurance company. If you have any questions about our policy, please do not hesitate to ask.

**PATIENT'S NAME:**

**NAME, AS IT APPEARS ON CREDIT CARD:**

**BILLING ADDRESS:**

**ZIP CODE:**

**CARD #:**

**EXPIRATION DATE:**

**VERIFICATION CODE (3 or 4 DIGITS):**

By signing below, I agree with the above policies and authorize Synergy Primary Care to keep my signature and my credit card information securely on file in my account. I authorize Synergy Primary Care to automatically charge my credit card, debit card, or HSA card for any outstanding balances such as cost-sharings, copayments, coinsurances, deductibles, and/or other charges not covered by my insurance plan from now on.

If the payment method that I provide today changes, expires, or is denied for any reason, I agree to update Synergy Primary Care in writing with a new, valid credit/debit/HSA card that will be subject to the policies above. I certify that I am the authorized user of this payment method.

**Patient Name: _____**

**Patient Signature: _____**

**Date: _____**