

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

PATIENT INFORMATION

FULL NAME _____ DATE OF BIRTH ___/___/___ AGE ___ GENDER: MALE FEMALE

ADDRESS _____ APT # _____ SSN ___-___-_____

CITY _____ STATE _____ ZIP CODE _____ PHONE (____) _____-_____

CELL PHONE (____) _____-_____ EMAIL _____@_____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

WORK PHONE (____) _____-_____ EXT _____ HOW DID YOU HEAR ABOUT US? _____

MARITAL STATUS: SINGLE MARRIED WIDOW PARTNERED

EMERGENCY CONTACT _____ PHONE NUMBER (____) _____-_____ EXT _____

PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN _____ PHONE NUMBER (____) _____-_____

OTHER DOCTOR _____ PHONE NUMBER (____) _____-_____

CLAIM INFORMATION

IS THIS CONDITION DUE TO: AUTO ACCIDENT PERSONAL INJURY WORK INJURY OTHER

TYPE OF CLAIM: CASH GROUP HEALTH INSURANCE PERSONAL INJURY WORKER'S COMP MEDICARE

TODAY I WILL BE PAYING BY: CASH CHECK MASTERCARD AMEX DISCOVER OTHER

INSURANCE INFORMATION

RELATIONSHIP TO INSURED: SELF CHILD SPOUSE SPOUSE'S NAME _____

INSURED'S EMPLOYER: SAME AS ABOVE OTHER _____

INSURED'S SSN AND DOB: SAME AS ABOVE OTHER: SSN: _____-_____-_____ DOB: _____-_____-_____

PRIMARY INSURANCE CO _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE NUMBER (____) _____-_____

SECONDARY INSURANCE CO _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE NUMBER (____) _____-_____

POLICY NUMBER _____

AUTHORIZATIONS

1. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
2. I authorize payment of any medical benefit from third parties for benefits submitted from my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I know or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products or services rendered.
3. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT'S SIGNATURE _____ **DATE** _____

GUARDIAN'S SIGNATURE _____ **DATE** _____

Welcome to Physical Synergy

Your name: _____



Who can we thank for referring you to our office?

Family: _____

Friend: _____

Website: _____

Drive by: _____

Do you take Yoga here?: _____

Other (please specify): _____



Would you like to receive text messages confirming your appointments?

We will send you a text message the night before your appointment instead of calling you letting you know the date and time of your appointment. If you would like to sign up for this please provide the information below:

Cell phone number: _____

Cell phone carrier: _____

Signature: _____ date: _____



Manual Therapy Appointment Cancellation Policy

If you need to cancel your manual therapy appointment please give us 24 hour notice. We do charge \$50 for no shows or appointments that were not cancelled within the 24 hour time line.

Patient Signature: _____ date: _____

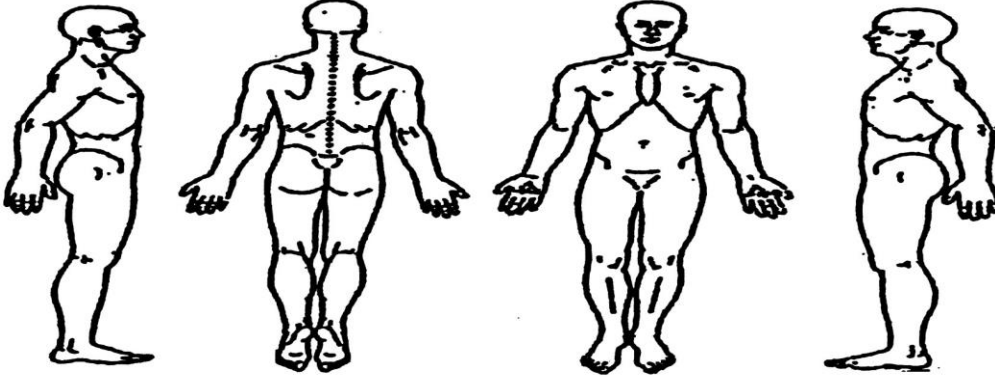
Emp In: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation Personal Injury

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Intermittent (26-50% of the time)
 Frequently (51-75% of the time) Occasional (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

13a. What alleviates your problem?

14. What concerns you the most about your problem?

Office Policy and Insurance

This agreement is between PHYSICAL SYNERGY and _____.(patient name)
I _____(patient name), do hereby authorize and agree to pay for services rendered to me by DR. MICHAEL TROKNYA, and/or DR. MATTHEW MEYERS during my course of treatment as agreed upon. I also hereby authorize and agree to pay in full any outstanding balance due on my account if requested at the time of my release from care.

I instruct an insurance carrier that may be liable to pay my physician directly for any outstanding medical bills.

I understand that if I have a personal injury protection policy (PIP) that it is the contractual obligation of my insurer to pay any and all medical bills, which are the result of an automobile accident, unless my benefits have been exhausted. I instruct any insurance company that may be liable to pay to pay my doctor within 30 days of the date of receipt of my claims, as required by the Connecticut Department of Insurance, by way of issuance of a separate draft make payable to PHYSICAL SYNERGY.

In the event I so choose to have any attorney represent me in this case, I do hereby instruct said attorney to pay in full any outstanding monies due my physician at the time of settlement with any liability claim that may result from this case. My attorney shall not withhold any portion of the amount due to my physician under this agreement to offset attorney's fees. I also instruct my attorney to pay my doctor immediately upon settlement, by way of issuance of a separate draft made payable to PHYSICAL SYNERGY.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by any insurance companies. I am instructing and agreeing to the above conditions as a safeguard to the physician's right to collect payment.

I understand that PHYSICAL SYNERGY has the right to expect good faith payments on my account and that full payment is being deferred only until such time as any insurance company makes payment on my account. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full.

I understand that PHYSICAL SYNERGY does not render any services on the assumption that their charges will be paid by any insurance company. Patients who carry health insurance should remember that professional services are rendered and charged to the patient if not paid in full by the insurance company. This excludes patients with an accepted workers' compensation injury. Insured patients are expected to take care of their fees and/or patient portion as services are rendered. Even though an insurance claim is filed, you will receive a statement if your account has a balance due.

Methods of payment

(Accepted workers' compensation patients are excluded)

- A. Payment at the time of service is expected unless prior arrangements are made in advance. Cash, checks and credit cards are accepted.
- B. If participating in the Well Care Program, which allows the patient to pay in advance for the recommended adjustments, and thereby receive subsequent savings, or other cash payment agreement, the patient's insurance company will not be billed. However, if the patient suffers an injury or illness, which merits injury/illness care, the patient's insurance may be utilized.

Patients Signature

Date

Patient's Parent or Guardian Signature

Date

Acknowledgement and Agreement of Receipt

As the insurance adjuster or attorney on this claim, I acknowledge that I have received notice of the patient's agreement above and will abide as agreed upon and instructed from _____ (patient's name).

Adjuster or Attorney Signature

Date

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient and "Chiropractor" refers to Physical Synergy

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information what will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Physical Synergy. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in The Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient/Personal Representative

Printed Patient Name

Date of Signing

Description of Personal Representative's Authority



Michael Troknya, D.C. * Matthew Meyers, D.C. * R. Alex Swartz, D.C.
340 Post Road, Fairfield, CT 06824
Tel: (203) 259-3210 Fax: (203) 259-3213

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for Physical Synergy regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by clinic and my respective rights contained therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting Jeanine Puma, Clinic Privacy Officer, 203-259-3210, 340 Post Road, Fairfield, CT 06824

My signature herein below constitutes full acknowledgement that I have been furnished a copy of the Notice of Privacy Practices for Physical Synergy.

Patient Signature/parent or guardian	Date
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Patient's legal representative (if required)	Date
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I signed by a patient's legal representative, please state representative's relationship to patient
