Synergy
Advanced Healthcare LLC
Primary Care, Medication Management, Counseling

Patient Information

First Name: _____ Last Name: _____ Date:_____

Preferred First Name: _____

Parent/Legal Guardian if under 18 years of age: _____

Date of Birth: _____ Sex: _____ Gender Identity _____

Mailing Address: Street: _____ City: _____

State: _____ Zip code: _____

Mobile Phone: _____ Home Phone: _____

Email: _____

By providing Synergy Advanced Healthcare LLC with a mobile phone number and or email address, you are authorizing Synergy Advanced Healthcare LLC to contact you via phone, text/SMS messaging and/or email regarding upcoming appointments and bulk communication from the office. You may opt out of these communications at any time.

An initial new patient appointment and evaluation is not an agreement of care and does not constitute a provider/patient relationship. _____ Initial

Marital Status: _____

Emergency Contact

Name: _____ Relationship to self: _____

Cell/Home Phone#: _____

Pharmacy Information

Preferred Pharmacy: _____

Synergy Advanced Healthcare LLC

Insurance Information

I am uninsured or will not be using my health insurance for my care at Synergy Advanced Healthcare LLC. I understand that I will pay in-full, the office cash price for all services at the time of service. No Balance may be carried.

Initials _____

I will be using the below insurance information for my care at Synergy Advanced Healthcare LLC. I understand that I am responsible for all co-payments, co-insurances, deductibles, or non-covered services associated with my visits.

Initials _____

Policy Holder Information: Subscriber's Name_____

Insured's Date of Birth:_____Insured's Phone:_____

Insured's Address: Street: _____ City: _____

State: _____ Zip code: _____

Primary Insurance Insurance Carrier: _____

I.D.#:_____Group#:_____

Relationship to Insured: Self_____ Spouse _____ Child_____

Secondary Insurance Insurance Carrier: _____

I.D.#:_____Group#:_____

Relationship to Insured: Self_____ Spouse _____ Child_____

Authorizations and Release of Information:

I authorize release of information to all my insurance companies and the use of my signature on this form for all my insurance submissions. I authorize payment directly to my provider although I understand that I am responsible for my bill and for any costs involved in collection. I permit a copy of this authorization to be used in place of the original on insurance submissions.

If I do not sign this consent, or later revoke it, the Synergy Advanced Healthcare LLC may decline to provide treatment to me.

Signature _____ Date_____

Synergy Advanced Healthcare LLC

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies, and health insurers and Controlled Substance Monitoring, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

If I do not sign this consent, or later revoke it, Synergy Advanced Healthcare LLC may decline to provide treatment to me.

Signature: _____ Date: _____

By signing this consent form, you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV, Substance Use Disorders and Mental Health issues.

Synergy Advanced Healthcare LLC

PATIENT AUTHORIZATION FORM

Authorization to Release Information (ROI)

Many of our patients allow family members or other individuals such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members or any other individual you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Synergy Advanced Healthcare LLC to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____ Phone: _____
2. _____ Relation to Patient: _____ Phone: _____
3. _____ Relation to Patient: _____ Phone: _____
4. _____ Relation to Patient: _____ Phone: _____

Signature: _____ Date: _____

Synergy Advanced Healthcare LLC

Patient Responsibilities

Synergy Advanced Healthcare LLC maintains the highest patient care standards and has a responsibility to our patients to provide this care. As a patient, you also must be committed and involved in your healthcare. If at any time you are unable/unwilling to continue your commitment/involvement in your healthcare, including the following, Synergy Advanced Healthcare LLC reserves the right to discharge you from the practice for the following reasons:

- Non-compliance with taking medication(s) as prescribed.
- Non-compliance attending scheduled appointments.
- Non-compliance with provider care instructions including attending referred specialist appointments.
- Failure to treat the staff, providers, or other patients with respect either in the office or via telephone will result in immediate discharge from the practice.
- Physical or verbal abuse/threats will result in immediate discharge from the practice and result in legal action.

If I do not sign this notice of policies, Synergy Advanced Healthcare LLC may decline to provide treatment to me.

Signature: _____ Date: _____

Synergy Advanced Healthcare LLC Office Policies

Cancellation/No-Show and Late Arrivals

Synergy Advanced Healthcare requires a 2-business day notice to cancel any appointment. In the event an appointment is canceled without the required advanced notice and or failure to show for appointments as scheduled, the following policy will apply:

- 2 No-Shows or Late Cancellations in any rolling 2-month period.
    - The practice reserves the right to discharge the patient.
- 3 No-Shows or Late Cancellations in any rolling 3-month period.
    - The practice reserves the right to discharge the patient.
- Late arrival to an appointment, including telemedicine, may result in rescheduling.
    - ***The practice does not offer a "grace period" for appointment times.***
- **Failure to confirm any appointment at least 2 business days before the scheduled appointment time may result in the appointment being canceled.**
    - ***Notice of cancellation will be given by phone, text, or email.***

Co-Payments/Co-Insurance and Plans with Deductibles

All Co-Payments are due at the time of service. If for any reason a balance is due after insurance processing, payment is expected within 30-days of your visit or before your next visit, whichever is sooner. Synergy Advanced Healthcare LLC provides online payment options and accepts all major credit cards in the office.

Co-pays for Telemedicine/Counseling visits are the same as in-office visits unless otherwise specified by your insurance carrier.

If your insurance plan has a high deductible, you will be required to provide payment-in-full for the office visit at the time of service. Synergy Advanced Healthcare LLC will apply that payment towards your deductible.

Failure to pay co-payments/co-insurance or any outstanding responsible party balance on your account may result in discharge from the practice and having your debt transferred to a collection agency.

Medication Refill Policy

All medication refill requests must allow for two business days to be processed. As a practice policy, prescriptions are filled from "appointment to appointment". ***If a patient misses a scheduled appointment, there is no guarantee that your provider will fill a prescription outside of an office visit.***

Medication refill requests that are too early to refill will not be processed until the due date.

If I do not sign this notice of policies, Synergy Advanced Healthcare LLC may decline to provide treatment to me.

Signature: _____ Date: _____

Synergy Advanced Healthcare LLC

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.
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. ***Full policy is available upon request.***

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Signature: _____ Date: _____