



1700 Thomas Paine Pkwy
Centerville OH 45459
P: 937-428-6273
F: 937-428-6274

Patient Name:

Address:	
Physician Name:	
Address:	
Insurance name and address: Policy/ID number Group number	Primary
Insurance name and address: Policy/ID number Group Number	Secondary

Medical History:

Current diagnosis: _____

Surgeries or procedures in the past year:

Precautions: _____

Current concerns:

All of the above forms are located on our website and available upon request.

- I agree to allow Synergy Family Therapy Specialists, Inc. to take photographs or videos of me and /or my child to be used for educational and learning purposes or for promotional items.
- I have read and understand the billing and collection policies
- I have read and understand the patient cancellation / no show policy
- I have read and understand the HIPPA act

I grant permission for Synergy Family Therapy Specialists to share information regarding treatment/procedures that are necessary or advisable for my care. I consent for Synergy to exchange and / or release requested information on my medical care to my insurance carrier(s) and to:

- Patient/guardian
- Attorney
- Physicians _____
- School _____
- Other _____

Patient or parent signature

Date