Synergy
FAMILY THERAPY SPECIALISTS

1700 Thomas Paine Pkwy
Centerville OH 45458
P: 937-428-6273
F: 937-428-6274

Welcome Letter

Thank you for choosing Synergy Family Therapy Specialists! We look forward to providing you with the best care possible and assisting you to reach your maximum potential. We are located at the above address and open Monday through Friday from 8:00 am to 6:00 pm.

Enclosed you will find a patient intake form, medical history form, photo release and insurance verification questionnaire. We ask that you complete and return this information to us prior to your first appointment, so we can prepare for your time with us.

Please feel free to call us with any questions you may have as you complete the above forms.

Sincerely,

Synergy Family Therapy Specialists

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Patient Intake Form

Patient Information

Last Name:	First Name:	Middle Initial:
Address:	City:	Zip Code:
Home Phone:	Cell Phone:	Email Address:
Date of Birth: SSN:	Sex: M / F	Marital Status:

Employer Information

Employer Name:	Employment Status:	☐ Full Time ☐ Part Time ☐ Retired ☐ Student	
Address:	City:	State:	Zip Code:
Work Phone Number:	Patient Occupation:		

Emergency Contact Information

Contact Name:	Phone Number:	Relationship to Patient:

Physician Contact Information

Name of Referring Physician:_____ Telephone Number: _____

Family Doctor: _____ Telephone Number: _____

Additional Questions

Auto related: ☐ Yes ☐ No	Work Related: ☐ Yes ☐ No	Accident Related: ☐ Yes ☐ No	Body Part/Diagnosis	Date of Injury:

MEDICARE ONLY –Additional Questions

If Medicare, are you currently receiving Home Health Services: ☐ Yes ☐ No If Yes, name of agency? _____
If yes, what type of Home Health Services are you receiving? _____ Last Date of Service? _____
Are you currently residing in a Skilled Nursing Facility? ☐ Yes ☐ No If Yes, Name of Facility: _____

If Medicare, have you received PT, OT or Speech Therapy services since the first of the year? ☐ Yes ☐ No If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐ Yes ☐ No

Patient Signature:_____ Date: _____

Insurance Information

Last Name:	First Name:	Middle Initial:	SSN:	DOB:
Patient relationship to Policy Holder:			Gender: M / F	
Employer Name:		Employer Phone Number:		
Primary Insurance Section		**Secondary Insurance Section**		
Payor/Plan:		Payor/Plan:		
Policy/ID Number:		Policy/ID Number:		
Group Number:		Group Number:		

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

☐ Workers Compensation ☐ Patient/Guardian ☐ Attorney ☐ Rehabilitation Intermediary/School

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me to the insurer of Synergy Family Therapy Specialists, Inc. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information/welcome letter from Synergy Family Therapy Specialists, Inc.

_____

Client's Signature Date

I have read and understood Synergy Family Therapy Specialists, Inc.'s privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request.

_____

Client's Signature Date

I have read and understand Synergy Family Therapy Specialists Inc.'s billing and collection policies, initial disclosure, and cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request.

_____

Client's Signature Date

_____

Responsible Party's Signature (If patient is a minor) Date

_____

Witness Signature Date

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Medical Information Form – Pediatrics

Child's Name: _____ DOB: _____
Person completing the form: _____Relationship:_____

Birth History:
Child was born: ____ Full term or ____ Premature. If premature, how many weeks? _____
Is the child adopted:_____
Delivery: ____ Vaginal ____ with forceps ___C-section
Were there complications at birth or any medical problems noted?
_____
_____
_____

Medical History:
Current diagnosis: _____
Hospitalizations or Surgeries: _____
Current pediatrician: _____
Other physicians involved in the child's care:
_____
_____
Medications:
_____
_____
Allergies: _____

Precautions:
__ Fall Risk __ Hearing Loss __ Hx of Ear Infections __ Impaired Vision
__ Infectious Disease __ Latex Sensitivity __ NPO __ Seizures __ Spinal Instability
__ Splints/Braces __ Trach __ Tube Fed: _____
__ Weight Bearing: _____
__ Other: _____

Developmental History:

Please indicate at what age your child achieved the following milestones: (mark N/A for those they have not reached yet)

Rolled over		Sat alone		Crawled	
Pulled to stand		Stood alone		Walked alone	
Babbled		Said 1st words		Drank from cup	
Used spoon		Toilet trained		Dressed self	
Started Table Foods					

What skills can your child do alone (mark with an A) and what do they need help with (mark with an H)?

Dressing		Undressing		Tying Shoes	
Buttons/Fasteners		Bathing		Brushing Teeth	
Brushing Hair		Toileting		Using Forks	
Using Spoons		Using Knifes		Drinking from Cups	

Does your child have any vision concerns? Y/N? What was the date of their last exam? _____

Does your child have any hearing concerns? Y/N? What was the date of their last exam? _____

What additional activities/hobbies does your child participate in?

_____

_____

Describe current functional concerns:

_____

_____

_____

Any additional information that will be helpful for your child's therapist to know:

_____

_____

_____

Educational Information:

School/Daycare: _____ Grade: _____

Therapy received in school: ☐ PT ☐ OT ☐ Speech ☐ Vision ☐ Hearing

☐ Behavior Intervention ☐ Other Special Service: _____

Is your child currently receiving other therapy? Y / N. If yes, where? _____

Check if your child exhibit any of the following behaviors:

	Dislikes playground equipment		Troubles with changes in routine		Always on the go
	Frequent temper tantrums		Clumsiness		Dislikes hair brushing
	Anxious		Weak muscles		Dislikes tooth brushing
	Cries often		Mouths objects		Rocks self
	Sensitive to sound		Poor attention span		Sensitive to light
	Trouble with directions		Picky eater		Avoids touch
	Meals take more than 20 minutes		Struggles biting/chewing tough foods (ie. Meats, apples, carrots, etc.)		Coughs or chokes while eating/drinking
	Poor eye contact		Prefers to play alone		Open mouth at rest
	Drooling		Reflux		

What brought you to Synergy Family Therapy Specialists?

_____

Thank you for completing this information. It will allow our therapists to understand your child and your families concerns as well as strengths in order to provide the most comprehensive care possible.

_____

Signature of parent

_____

Today's Date

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Photograph Release

I, _____, agree to allow Synergy Family Therapy Specialists, Inc. to take photographs of me and/or my child, which may be used for educational and learning purposes or promotional items.

I also forfeit any monetary fees or profits which may arise from presentations given by Synergy Family Therapy Specialists, Inc. using these pictures.

Patient: _____

Signature:_____

Witness: _____

Date: _____

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Patient Insurance Verification Questionnaire

Before you call your insurance company, have ready:

Your name (as on your card): _____ Birth Date: _____

Subscriber Name (spouse/parent): _____ Birth Date: _____

ID Number: _____ Group Number: _____

Diagnosis (if possible – will be on prescription from doctor):_____

When you call your insurance company say:

"I am calling to verify my insurance for Physical Therapy/Speech Therapy/Speech Feeding Therapy in an **OFFICE** setting"

Note the date/time and person you are speaking with: _____

If they ask where you are having your therapy: Synergy Family Therapy Specialists

They will tell you:

Effective date of insurance: _____

Current deductible: _____How much of deductible has been paid: _____

Co-Pay _____ Co-Insurance: _____ % insurance will pay/_____% your responsibility

Number of visits allowed _____ per time limit _____ # visits used _____

Yearly/lifetime maximum: _____

Combined with Speech Therapy? Occupational Therapy? Chiropractic?

Out of pocket maximum _____ Then claims paid at _____%

Is pre-certification or prior authorization for treatment required: No/Yes

Phone number to call for authorization _____

Is authorization required at any time? _____

Do you require a referral from your physician? Yes / No

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Billing and Collection Policies

We welcome you as a new patient of Synergy Family Therapy Specialists. To keep you informed of our current office and financial policies we ask that you acknowledge, with your signature, having received our Policies and Procedures. Please keep this document for future reference.

Insurance

PLEASE CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS. We will verify your insurance for you. Please note that when we verify benefits, we are simply relaying information obtained from your insurance company and Synergy Family Therapy Specialists is NOT responsible for any erroneous information they might provide. (Please see "Patient Insurance Verification Questionnaire".)

For insurance plans that we contract with, that require co-pays, the co-pay must be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. Because of federal regulations, we are unable to extend courtesy or professional discounts to anyone, or to waive co-pays or deductibles. Any deductible and co-insurance amounts will be determined as you progress with your care.

Payment for any co-insurance, deductibles, or non-covered service as required by your insurance is expected at the time of service. **A receipt will be issued at that time, which will be your proof of payment. Proof of payment will be required when disputing whether or not a co-payment was made at the time of service.**

You will receive an Explanation of Benefits (EOB) from your insurance company indicating what they have paid and your financial responsibility. Any remaining balance is due upon receipt of that EOB. Please send this amount immediately to our remittance location at: Synergy Family Therapy Specialists, Inc., 1700 Thomas Paine Pkwy., Centerville, OH 45459. Any portion of your bill that is your responsibility will be billed to you after receipt of payments from your insurance company.

Cash-Pay

For patients who do not have insurance coverage, or have exhausted their physical therapy benefits, we offer a cash discount if paid at the time of service. Cash-pay services cannot be billed to your insurance. We provide this option to make your healthcare accessible and affordable.

We accept cash, check, MasterCard, VISA, and Discover. There will be a fee of $40 charged on all returned checks.

Again, we welcome you as a physical, occupational, and speech therapy patient, and will be happy to answer any questions you may have on the above policies.

Initial Disclosure

(This concerns any part of an account that reaches an age of 90 days or older from the time of service). In order to keep overhead costs to a minimum, there will be a 90 day period from the time service is rendered in which a bill may be paid without the addition of any FINANCE CHARGES. At that point in which any part of the balance becomes 90 days old, a FINANCE CHARGE will be assessed. The FINANCE CHARGE is 1.5% per month (periodic rate) which is 18.5% ANNUAL PERCENTAGE RATE. We figure (a portion of) the FINANCE CHARGE on your account by applying the periodic rate to the "90 DAY" part of your account. The "90 DAY" part of your account is arrived at by added together the amounts from the previous month that appear in the "60 DAY" and "90 DAY" columns of your bill (which is to say, any part of your account that is 60 days or older from the previous month), and subtracting from that column any payments or credits posted during the course of the present billing cycle. All account balances over 120 days will be turned over to an outside collection agency. A 25% collection fee may be added to your account balance if outside collection efforts are needed. Any previous account balances must be paid in full prior to receiving additional services.

If you think your bill is wrong, or if you need more information about a transaction on your bill, contact us at 1-937-428-6273.

We must hear from you no later than 30 days after we sent you the first bill in which the error of problem appeared.

You do not have to pay the amount in question while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. While we investigate your question, we cannot report you as delinquent or take any action to collect the amount you question.

_____

Client's Signature Date

_____

Responsible Party's Signature (If patient is a minor) Date

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Patient Cancellation/No Show

It is important for you to attend your therapy sessions, in order to allow you or your child, to make the most progress possible.

Synergy Family Therapy Specialists requests that any cancellations of appointments be made at least 24 hours in advance. The reason for cancellation, if provided by the patient, is noted in the patient's chart. Patients who fail to cancel 24 hours before their appointment will be subject to a $50 cancellation fee, per appointment. Synergy Family Therapy Specialists is willing to waive the cancellation fee if the patient reschedules their appointment, or at the discretion of the therapist. We have been lenient with our cancellation policy in the past, but will be enforcing it moving forward, as our overall goal of rescheduling appointments is to make sure that our patients continue to make adequate progress with intervention, to reach their goals.

Patients who fail to show for appointments are contacted as soon as possible after the scheduled appointment and prior to the next scheduled appointment. The purpose of this is to verify attendance for the next appointment and to educate the patient on the need for proper compliance with the treatment program. Patients who fail to attend their regularly scheduled appointments may be subject to removal from the therapist's permanent schedule after the second missed appointment. Your permanently scheduled appointment may be subject to removal from the therapist's permanent schedule, if frequent cancellations, including advanced cancellations, are made.

The referral source may be notified if the patient fails to show for appointments or is frequently non-compliant with their appointments. This is done through the regular progress report or through a no show/cancel form completed by the office secretary. These reports are generated on an as-needed basis.

Sibling Policy

At Synergy Family Therapy Specialists, we believe siblings can be a great motivator during sessions. If you bring siblings to therapy sessions, we ask that they are supervised by you or a designated adult at all times, as our main focus will be on your child receiving services. In the event that a sibling(s) becomes a distraction to the therapy session or to others, we may ask that you and your child(ren) wait in the family waiting room for the remainder of the session. If you feel that a sibling is no longer focused on assisting during a session and maybe taking away from the progress of the child, we ask that you intervene. Children not receiving therapy services must be supervised at all times and should never be left unattended while on Synergy Family Therapy Specialists' property. Thank you for your understanding.

_____

Client's Signature Date

_____

Responsible Party's Signature (If patient is a minor) Date