###### Synergy logo

**Patient Change of Information Form**

Please complete the section(s) that changed.

**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: |

**Emergency Contact Information**

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| --- |
| Contact Name: Phone Number: Relationship to Patient: |

**Physician Contact Information**

|  |
| --- |
| Name of Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Information**

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| --- |
| Only Complete the following if the Primary or Secondary policy holder is not the patient. Primary Secondary |
| 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).

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me to insurer of Synergy Family Therapy Specialists, Inc.

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Patient/Clients Signature Date