Synergy Primary Clinic, PLLC

2107 Eldorado Parkway, Suite 106, McKinney TX 75070
Phone: (469) 919-0003 Fax: (469) 422-6097
Synergyprimaryclinic.com

Patient Intake Form

Date: _____

Personal Information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work/Home Phone: _____

SSN: _____ Gender: M or F Age: _____ Date of Birth: _____

Marital Status: _____ Email: _____

Current Employer: _____ Occupation: _____

Preferred Pharmacy: _____ Mail Order Pharmacy: _____

Reason for Visit:

Chief Complaint (Why are you here?): _____

Emergency Contact Information:

Name of Person: _____

Phone: _____ Relationship with the person: _____

Insurance/ Billing Information:

Primary Insurance: _____ Policy/Contract Number: _____

Group Number: _____ Subscriber's

Name: _____

Subscriber's Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance: _____ Policy/Contract Number: _____

Group Number: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relationship to Patient: _____

Signature of Responsible Person: _____ Date: _____

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Medical History Form

Date: _____

Patient's Name: _____ **DOB:** _____

Past Medical History: (Circle all that apply):

Hypertension	Hyperlipidemia	Diabetes
Stroke/TIA	Seizure	Neuropathy
Coronary Artery Disease	Congestive Heart Failure	Atrial Fibrillation
Hypothyroidism	Chronic Kidney Disease	COPD/Asthma
Depression/Anxiety	Bipolar Disorder	Cancer

List here if not mentioned above: _____

_____

Medications:

Name of Medication	Strength	How many times a day

Past Surgical History:

_____ _____

_____ _____

Allergies: No Drug Allergies (Circle it if no drug allergies)

_____ _____

_____ _____

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Social History: (Circle all that apply)

- Tobacco: Current smoker Used to smoke Never smoked
- Alcohol: Drink daily Drink socially Never drank
- Illicit Drug use: Active Tried in past Never done drugs
- Employment: Currently working Not working Retired Disabled

Family History:

Relationship	**Condition**
Father	
Mother	
Brother	
Sister	
Children	

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Review of Symptoms Form

Date: _____

Patient's Name: _____ **DOB:** _____

Symptoms in last 6 months (Mark √ if symptoms present):

No	System	Symptoms	Yes
1	**Constitutional**	Fever	
		Fatigue	
2	**Eyes**	Droopy eyelid	
		Double vision	
3	**Ear, Nose, Throat – ENT**	Hearing loss	
		Difficulty in chewing/swallowing	
4	**Endocrine – Hormone**	Weight gain/loss	
		Heat/cold intolerance	
5	**Cardiovascular – Heart**	Chest pain	
		Palpitations	
6	**Respiratory – Lung**	Shortness of breath	
		Cough	
7	**Gastroenterology – GI**	Constipation/diarrhea	
		Nausea, vomiting	
8	**Renal – Kidney**	Swelling of feet	
		Foul smelling urine	
9	**Extremities**	Swelling	
		Redness on legs	
10	**Skin**	Skin lesion/ulcer	
		Itching	
11	**Hematology**	Easy bruising	
		Enlarged glands	
12	**Psychiatry**	Depression/anxiety	
		Mood swing	
13	**Neurology**	Seizure	
		Passing out episode/confusion	
		Tingling, numbness	
		Memory loss	
		Tremors	
14	**Musculoskeletal**	Neck pain	
		Lower back pain	

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PATIENT NAME: _____ LOCATION OF PATIENT: _____	DATE OF BIRTH: _____	MEDICAL RECORD #: _____
PHYSICIAN NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____		DATE CONSENT DISCUSSED: _____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

Patient medical records

Medical images

Live two-way audio and video

Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

Improved access to medical care by enabling a patient to remain in his/her physician's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.

More efficient medical evaluation and management. Obtaining expertise of a

distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);

Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;

In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Please initial after reading this page: _____

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By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My physician has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____Synergy Primary Clinic to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer, relationship to patient: _____

Witness: _____ *Date:* _____

I have been offered a copy of this consent form (patient's initials) _____

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Patient Name: _____ Date of Birth: _____

Financial Policy

- Copays, deductibles and outstanding balances are due upon arrival. Payments are due at the time services are rendered. We accept Cash, Credit/Debit Cards, HSA Cards, and Checks. There will be a $35 service charge for NSF of a returned check.
- It is the patient's responsibility to inform our office if you need to cancel or reschedule an appointment at least 24 hours in advance. There will be a $25 No Show/ Same Day Cancelation fee if done without a 24-hour notice.
- Patients are responsible to pay for any test/injections or procedures that insurance does not cover.
- It is the patient's responsibility to verify with their insurance about what service and treatment plans are covered by their insurance. If we submit claims and insurance rejects or denies the claim, the patient will be responsible for the payment.
- All payments and balances due must be paid within 30 days of receiving a statement in the mail.
- If we turn the pending balance on account to the collection agency, the fees associated with the collection agency will be the responsibility of the patient.
- There is a $ 35 charge for ALL forms needed to be filled out by the doctor.

Medication Refills

- We cannot fill any medication refills if you do not come for your follow-up appointment.

Updated Patient Information and Insurance

- You must bring all your insurance cards to your appointment. We re-verify insurance coverage at every visit.
- Please be sure to inform staff of any changes to your address, phone number, or insurance as soon as possible. We cannot give you any important information regarding your health if we do not have this.
- If you have new insurance, please call our office as soon as you get your new ID number so that we can verify BEFORE you come to your next appointment. This allows us to get you in quicker as less time will have to be spent on verifying your insurance. It is the patient's responsibility to verify that our office accepts their insurance. If your insurance denies any payment, it is the patient's responsibility to pay for their visit.

Photo Consent

- By signing this form, you are authorizing our practice to obtain photo documentation so that we may be able to properly identify you for medical treatment.

Patient or Responsible Person: _____ Relationship: _____

Signature of Patient or Responsible Person: _____ Date: _____

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Due to recent federal privacy guidelines (HIPAA), Synergy Primary Clinic, PLLC. is not allowed to release information to anyone other than the patient (or guardian of the patient) unless there is explicit authorization given to authorize Synergy Primary Clinic, PLLC. permission to discuss personal medical information with someone other than the patient or guardian of the patient. Please fill this form in order to allow us to discuss your information with the people of your choosing as listed below.

I, _____ give Synergy Primary Clinic permission to release/ discuss personal health information, which includes the pickup of prescriptions and/or financial information to/with:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that I may revoke this authorization at any time by sending a written notification to Synergy Primary Clinic, PLLC. **By signing this form, all previous lists of allowable contacts become invalid.**

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

I, _____ decline to give Synergy Primary Clinic, PLLC. permission to release/ discuss my personal health and/or financial information to anyone other than myself.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: _____ Patient DOB: _____ Address:

_____ City: _____ State: _____ Zip: _____
Social Security Number: _____ Telephone: _____

I hereby AUTHORIZE Synergy Primary Clinic to

☐ **Release Information to** **AND/OR** ☐ **Obtain Information from**

Name of Person/Company: _____
Phone Number: _____ Fax Number: _____
Address: _____ City: _____ State: _____ Zip: _____

Please Select Information to be Disclosed:

☐ All of my PHI (medical records) ☐ Lab Reports ☐ Progress Notes ☐ Diagnosis
☐ History and Physical ☐ Billing/ Financial Information ☐ Medication List
☐ Other: _____

Purpose of Disclosure of Information:

☐ Continuation of Care ☐ My Personal Use ☐ Litigation ☐ Other: _____

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before they received my written notice of revocation.

By signing this authorization, I hereby authorize the entities listed above to disclose my personal health information. I understand that information contained in my PHI may include information related to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. By signing this authorization, I understand that my PHI described herein may be disclosed by the entities above to receive and use my PHI and that my PHI described herein may no longer be protected by federal privacy regulations.

Patient Name: _____

Patient Signature: _____ Date: _____

Legal Representative: _____ Date: _____

Relationship to Patient: _____
Witness: _____ Date: _____

Card # _____ Exp. Date (Mo/Year)_____/_____

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ASSIGNMENT OF BENEFITS, AGREEMENT, AND GUARANTY

I authorize Synergy Primary Clinic, PLLC to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to Synergy Primary Clinic. If the check must be made out to me, I understand the check must be sent to this address: 2107 Eldorado Parkway, Suite 106, McKinney TX 75070. I understand that Synergy Primary Clinic must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect necessary otherwise is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

SYNERGY PRIMARY CLINIC NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I acknowledge that a copy of the Notice of Privacy Practices for SYNERGY PRIMARY CLINIC has been made available to me. In connection with the notice, I also acknowledge that I have been provided with an opportunity to ask any questions regarding the
notice and its contents.

Patient/ Legal Rep Signature: _____ Date: _____

Legal Rep Relationship to Patient _____ Date: _____

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Patients' Rights and Responsibilities

Please Keep for Your Records

1. Care shall be provided impartially without regard to race, creed, sex, or national origin.
2. Patients are entitled to considerate, respectful, and dignified care at all times.
3. The patient has the right to receive care in a safe setting.
4. Patients are entitled to personal and informational privacy as required by law. This includes the right to:
    a. Refuse to see or talk with anyone not officially affiliated with Synergy Primary Clinic;
    b. Wear appropriate personal clothing, religious, or other symbolic items that do not interfere with prescribed treatments or procedures;
    c. Examination in reasonably private surroundings, including the right to request a person of one's own gender present during certain physical examinations;
    d. Have one's medical records read and discussed discreetly.
    e. Confidentiality regarding ones individual care and/or payment sources;
    f. Data Privacy Rights as described in the Notice of Privacy Practices.
5. Patients and/or patients legally designated representatives have the right of access to information contained in the patient's medical record, within the limits of the law and in accordance with Synergy Primary Clinic policies.
6. Patients of Synergy Primary Clinic have the right to know the identity and professional status of all persons participating in their care.
7. Patients are entitled to know the status of their condition including diagnosis, recommended treatment and prognosis for recovery.
8. Patients have the right to be free from physical restraints which are not medically indicated or necessary.
9. Patients have the right, in collaborating with their physicians to make decisions involving their health care, including acceptances or refusal of medical care or treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
10. Patients are entitled to formulate advance directives and appoint a surrogate to make healthcare decisions on their behalf of the extent permitted by law.
11. Patients are entitled to receive an itemized detailed explanation of charges related to services rendered on their behalf.
12. Patients will not be transferred to another facility or location without explanation of the necessity of such action.
13. A patient's guardian, next of kin, or legally authorized responsible person may exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient has been judged incompetent in accordance with the law, or procedure, or is unable to communicate his/her wishes regarding treatment, or is a minor.
14. Patients have the right to appropriate assessment and management of pain.
15. Patient have the right, subject to the patient's consent, to receive visitors whom they designate, including, but not limited to, a spouse, domestic partner (including same-sex domestic partner), another family member, or a friend. Patients have the right to withdraw or deny any such consent at any time.
16. Patients are responsible for providing Synergy Primary Clinic with complete and accurate information regarding present and past illnesses and operations, hospitalizations, medications, and other health related issues, including any unanticipated changes in their condition.
17. Patients are responsible for following recommended treatment plans prescribed and/or administration.
18. Patients who refuse prescribed treatments or do not follow their practitioner's instructions assume full responsibility for the consequences of such actions.
19. Patients are responsible for ensuring prompt and complete payment of their account at Synergy Primary Clinic.
20. All patients must follow Synergy Primary Clinic rules and regulation relative to patient care and conduct. This includes consideration and respect for the rights and property of other patients and Synergy Primary Clinic providers and staff, as well as responsibility for the actions of their visitors and guests.