SYNERGY
PHYSICIANS

New Patient Packet

Patient _____ Last Name _____ First Name _____ Middle Initial

Sex ☐ M ☐ F Age _____ Date of Birth MM / DD / YYYY Social Security No. _____

Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Sep. Spouse (or parent if a minor) _____ Last Name _____ First Name

Home Address _____ Street _____ City _____ State _____ Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

Preferred Pharmacy _____ Pharmacy Contact Number (_____) - _____ - _____

Pharmacy Address _____ Street _____ City _____ State _____ Zip Code

Emergency Contact _____ Last Name _____ First Name _____ Relationship _____

Address _____ Street _____ City _____ State _____ Zip Code _____ Phone _____

Referring Physician / Source _____ Phone _____

Primary Insurance Company _____

Identification No. _____ Group No. _____ Effective Date MM / DD / YYYY

Policy Holder _____ Last Name _____ First Name Social Security No. _____ Date of Birth MM / DD / YYYY

Relationship to Patient _____ Employer _____

Secondary Insurance Company _____

Identification No. _____ Group No. _____ Effective Date MM / DD / YYYY

Policy Holder _____ Last Name _____ First Name Social Security No. _____ Date of Birth MM / DD / YYYY

Relationship to Patient _____ Employer _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim. **I understand that I am responsible for all charges not covered by my insurance.** If this account should be referred to a collection agency, I will be responsible for all collection and legal fees. I authorize the release of any medical or other information necessary to process my medical claims. I also authorize payment of government benefits either to myself or to the party who accepts assignment. I have read and understand the office policy and procedures.

_____ _____

Signature of the Patient or the Patient's Legal Representative Date

_____ _____

Print Name If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

Confidential Communications Form

This form helps us understand how you want us to communicate with you, or others, about the care we provide you. You can choose what modes of communication you would like us to use and who we can share information with. We may need to communicate test results, prescription information or respond to a message you left with your physician's office. By completing this form, you understand the following:

- This form gives us permission to communicate with you in a manner that you choose.
- You can change your decisions on this form at any time by completing a new form. We cannot change information on this form over the phone. If you want anything changed on this form, it is your responsibility to contact us to complete a new form. You will be asked to review or update this form at least annually on your next visit to our office.
- If you give us permission to communicate your health information to someone else, you understand that this could include any information in your medical record including test results, medications, diagnoses, procedures, etc.

Patient Name: _____ DOB: _____

Please tell us how you would like us to communicate information to you by checking all the boxes that apply:

You may contact me by telephone/text/voice mail: **Cell Home** (_____) _____ - _____

You may contact me by e-mail. E-mail address: _____

Please list the name(s) of the person(s) below who you give us permission to communicate your health information and the kind of information you permit us to communicate:

Name and Phone Number	This person's relationship to you	Information we can share (check box)
		Billing information Appointment information Medical information
		Billing information Appointment information Medical information
		Billing information Appointment information Medical information

By signing below, you allow us to communicate your health information to you, and permit us to share your health information with other persons, as indicated above.

Patient Name (Please Print)	Patient Signature	Date of Signature
Patient's Legal Representative (if patient can't sign) (Please Print Name)	Patient's Legal Representative Signature	Date of Patient's Legal Representative Signature

SYNERGY
HEALTH

Patient Health History

Please complete all applicable questions to the best of your knowledge. If necessary, you may use the space at the end of this form to complete any answers or provide additional information.

Patient_____ Date of Birth: ____/_____/_____

Do you have a living will? □Y □ N

Medical Conditions

If either you or a family member has or had any of these conditions, check (✔)the box by the condition listed. For family members, indicate their relationship to you (e.g. mother, father, sibling). Please provide a brief description.

Condition	Self	Description	Family Member	Description
ADD/ADHD				
AIDS/HIV				
Abuse/Domestic Violence				
Allergies/ Hay Fever				
Anemia				
Anesthesia Complications				
Anxiety Disorder				
Arthritis				
Asthma				
Autism				
Bedwetting				
Birth Defects/ Inherited Disease				
Bladder or Kidney problems				
Blood Diseases				
Blood Transfusion				
Breast Problems				
Cancer				
COPD				
Lung/ Liver Disease				
Reflux/ GERD				
MRSA Exposure				
Meniere's Disease				
Ovarian Cancer				
Polyps				
Skin Problems				

Patient Health History Cont.

Condition	Self	Description	Family Member	Description
Chicken Pox				
Chronic Ear Infections				
Congestive Heart Failure (CHF)				
Coronary Artery Disease				
Depression				
Developmental/ Behavioral disorders				
Diabetes				
Difficulty swallowing				
Diverticulitis				
Ear of hearing problems				
Eating Disorder				
Eczema				
Endometriosis				
Fibromyalgia				
Tuberculosis				
Vision or Eye Problems				
GI Problems				
Gout				
Stroke				
Heart Disease/ Problems				
Hepatitis				
High Cholesterol				
Hypertension				
Hyperthyroidism				
Hypothyroidism				
Infertility				
Kidney Disease				
Muscle, Joint, Bone Problems				
Osteoporosis				
Pre- Eclampsia				
Pulmonary Embolism				
Thrombophilias				
Other:				

PROBLEM CHECKLIST

If you have recently or recurrently noted the any of the following problems, please check (✓) the box next to the condition listed.

General	☐ Fever	☐ Chills
	☐ Sweats	☐ Malaise or "feeling ill"
	☐ Unintended weight change (how much over what period? _____)	☐ Fatigue
Head	☐ Headache	☐ Head injury
Ears	☐ Ringing	☐ Change in hearing
	☐ Ear pain	☐ Blockage
	☐ Ear discharge	☐ Dizziness
Nose	☐ Congestion	☐ Clear discharge
	☐ Persistently discolored discharge	☐ Post nasal drip
	☐ Sinus pressure	☐ Sinus pain
Throat	☐ Sore throat	☐ Dental problem
	☐ Laryngitis	☐ Persistent hoarseness
	☐ Itchy throat	☐ Snoring
Eyes	☐ Change in vision	☐ Sudden loss of vision
	☐ Flashing or scintillating lights	☐ Dark spots or "floaters"
	☐ Partial loss of vision (central, peripheral, or field)	☐ Eye discharge
	☐ Eye pain	☐ Itchy or irritable
Heart	☐ Chest pain or pressure	☐ Palpitations
	☐ Swelling of feet or ankles	☐ Racing heart
Lungs	☐ Trouble breathing (intermittent or constant)	☐ Wheezing
	☐ Cough	☐ Painful breathing
Digestive	☐ Heartburn or acid reflux	☐ Abdominal pain
	☐ Nausea	☐ Vomiting
	☐ Diarrhea	☐ Constipation
	☐ Blood in stool	☐ Black tarry stool
	☐ Excessive bloating or gas	
Bones and Joints	☐ Back pain	☐ Neck pain
	☐ Joint pain (stiffness or restricted mobility)	☐ Muscle aches
Neurological	☐ Weakness	☐ Numbness
	☐ Abnormal sensations	☐ Fainting
	☐ Seizures	☐ Restless legs
Psychological	☐ Anxious	☐ Panic attack
	☐ Feeling hopeless, helpless, or worthless	☐ Persistent sadness
	☐ Unable to enjoy life	☐ Insomnia
	☐ Uncontrollable anger or irritability	☐ Poor appetite or stress eating
	☐ Wanting to hide, disappear, or die	☐ Wanting to hurt someone
Skin	☐ Abnormal or changing mole	☐ Rashes
	☐ Lesions of concern	☐ Dryness
	☐ Swollen glands	☐ Bruising
	☐ Change in texture	☐ Hair or nail changes

IMMUNIZATIONS

Please list month and year of your most recent immunizations.

Hepatitis A MM / YYYY	Measles MM / YYYY	Tetanus[1] MM / YYYY	Chicken Pox MM / YYYY
Hepatitis B MM / YYYY	Flu[2] MM / YYYY	Pneumonia[3] MM / YYYY	Meningococcal MM / YYYY
_____ MM / YYYY	_____ MM / YYYY	_____ MM / YYYY	_____ MM / YYYY

[1] *Recommended every 10 years* [2] *Recommended every year* [3] *Recommended every 5 years*

ALLERGIES

Are you allergic or intolerant to any medications? ☐ Y ☐ N

If "yes," please list and describe your reaction(s).

_____

_____

_____

MEDICATIONS

Please list all medications you are using including vitamins, herbal supplements, and contraception.

_____

_____

_____

_____

SURGERIES

Please list any surgeries or procedures (include colonoscopies) you have had with approximate dates.

_____

_____

_____

_____

PREVENTIVE HEALTH

Please provide the following information:

Caffeine? ☐ Y ☐ N Type: _____ Caffeinated beverages per day? _____	Alcohol? ☐ Y ☐ N Type? _____ Drinks per week? _____ Quit date? MM / YYYY
Tobacco? ☐ Y ☐ N Type: _____ Packs per day? _____ Quit date? MM / YYYY	Other substances? ☐ Y ☐ N Drug(s)? _____ Frequency? _____
Seat belts? ☐ Always ☐ Occ. ☐ Never	Helmet use? ☐ Always ☐ Occ. ☐ Never
Drive at speed limit? ☐ Always ☐ Occ. ☐ Never	Protective sports gear? ☐ Always ☐ Occ. ☐ Never
Number of days >30 minutes exercise per week? _____	Foreign travel planned? ☐ Y ☐ N
Do you have reason to fear for your safety? ☐ Y ☐ N	Have you ever been physically or mentally harmed by another? ☐ Y ☐ N
Other "high risk" activities (*e.g.*, skydiving, motorcycles, scuba diving)? ☐ Y ☐ N Type? _____	

FOR WOMEN

Please provide the following information:

Number of pregnancies? _____ How many resulted in live birth(s)? _____ Miscarriage(s)? _____ Abortion(s)? _____	
Date of last period? MM / YYYY	Could you be pregnant now? ☐ Y ☐ N
Last Pap Smear or female exam? MM / YYYY	Last mammogram? MM / YYYY
Method of birth control? _____	Age at first period or menopause? _____
Prior abnormal Pap Smear? ☐ Y ☐ N If so, year: YYYY	Sexually active? ☐ Y ☐ N
History of human papilloma virus? ☐ Y ☐ N	Planning pregnancy in next year? ☐ Y ☐ N

FOR MEN

Please provide the following information:

Last PSA (blood prostate level)? MM / YYYY	Sexually active? ☐ Y ☐ N	
Urine flow problems? ☐ Y ☐ N	Prostate problems? ☐ Y ☐ N	Lump or pain in testicle? ☐ Y ☐ N
Erection issues? ☐ Y ☐ N	Loss of height? ☐ Y ☐ N	Lack of energy? ☐ Y ☐ N

FOR CHILDREN

Please provide the following information:

Normal development? ☐ Y ☐ N	School performance issues? ☐ Y ☐ N
Normal growth? ☐ Y ☐ N	Social or friends concerns? ☐ Y ☐ N
Normal language? ☐ Y ☐ N	Behavioral concerns? ☐ Y ☐ N

Is there anything of an unusually sensitive nature you would like to discuss with your physician? ☐ Y ☐ N

_____

_____

ADDITIONAL INFORMATION

Please use this space to complete any of the above questions or provide other relevant information.

_____

_____

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_____ _____

Signature of the Patient or the Patient's Legal Representative Date

_____ _____

Print Name If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

SYNERGY
PHYSICIANS

9070 E Desert Cove Ave Suite
#A102 Scottsdale AZ, 85260
P: 480-553-6168
F: 480-590-6235
www.TheSynergyHealth.com

Authorization to Disclose Protected Health Information to Synergy Physicians P.L.L.C.

Patient whose Protected Health Information is sought:

Patient _____ Last Name _____ First Name _____ Middle Initial _____ Date of Birth __MM__ / __DD__ / __YYYY__

Home Address _____ Street _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Person or entity *from* which Protected Health Information should be disclosed ("Provider"):

Name _____ Name of Person or Entity _____

Address _____ Street _____ City _____ State _____ Zip Code _____ Phone Number _____

Entity *to* which Protected Health Information should be disclosed:

Synergy Physicians P.L.L.C.
9070 E Desert Cove Ave, Suite
#A102
Scottsdale, AZ 85260

Attn: _____

Description of Protected Health Information to be disclosed:

- ☐ Complete Medical Record
- ☐ History and Physical Exam
- ☐ Operative Reports
- ☐ X-Ray Reports
- ☐ Lab Tests
- ☐ Other _____ Specify _____

Purpose(s) of the disclosure:

- ☐ Supplemental Care
- ☐ Second Opinion
- ☐ Transfer of Care
- ☐ Personal Use
- ☐ Insurance Coverage or Payment of Care
- ☐ Workers' Compensation
- ☐ Legal
- ☐ Other _____ Specify _____

I hereby authorize Provider to release Protected Health Information ("Information") to Synergy Physicians P.L.L.C. I understand that this authorization may cover Information relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eighty (180) days following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

_____ _____
Signature of the Patient or the Patient's Legal Representative Date

_____ _____
Print Name If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

SYNERGY
PHYSICIANS

Notice of Privacy Practices

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.

Synergy Physicians, P.L.L.C. ("Synergy") is required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. **Synergy** must abide by the terms set forth in this notice. However, **Synergy** reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information **Synergy** maintains. **Synergy** will post any revised notice in a prominent location in our office and, upon request, will provide to you a copy of the revised notice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Treatment. Synergy may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. Synergy may also disclose your protected health information to other health care providers who may be treating you or involved in your health care. For example, Synergy may disclose your protected health information to a specialist involved in your treatment.

Payment. Synergy may use and disclose your protected health information to obtain payment for the health care services Synergy provides you or to determine whether Synergy may obtain payment for services Synergy recommends for you. Synergy may also disclose your protected health information to another health care provider, health care clearinghouse, or health plan for their payment activities. For example, Synergy may include with a bill to a third-party payer information that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. Synergy may use and disclose your protected health information to support our business activities. For example, Synergy may use your protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. Synergy may disclose your protected health information for certain health care operations of another health care provider, health care clearinghouse, health plan for certain health care operations, and to an "organized health care arrangement" participates in for its health care operations. Synergy may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, Synergy may disclose to certain third parties a limited data set containing your protected health information for certain business activities.

Appointment Reminders and Treatment Alternatives. Synergy may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment, or to tell you about or to recommend possible alternative treatments or other health-related benefits or services that may be of interest to you.

Persons Involved in Your Care. Synergy may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, Synergy may disclose the information as necessary if Synergy determines that it is in your best interest based on our professional judgment.

Notification. Synergy may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location, general condition, or death.

Disaster Relief. Synergy may use and disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to

coordinate uses and disclosures to family or other individuals involved in your health care.

Research. Synergy may use and disclose your protected health information to researchers whose research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. Synergy may also disclose to certain third parties a limited data set containing your protected health information for research purposes.

As Required by Law. Synergy may use and disclose your protected health information to the extent the use or disclosure is required by law. If required by law, you will be notified of any such uses or disclosures.

Public Health. Synergy may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. Disclosures will be made for purposes of controlling disease, injury, or disability. If directed by the public health authority, Synergy may disclose your protected health information to a foreign government agency that is collaborating with the public health authority.

Abuse or Neglect. Synergy may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. If Synergy believes you are a victim of abuse, neglect, or domestic violence, Synergy also may disclose your protected health information to the governmental agency that is authorized to receive this information. All disclosures will be consistent with the requirements of the applicable laws.

Communicable Diseases. If authorized by law, Synergy may disclose your protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a communicable disease.

Legal Proceedings. Synergy may disclose your protected health information in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; to the extent the disclosure is expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request, or other lawful process.

Law Enforcement. If certain legal requirements are met, Synergy may disclose your protected health information to a law enforcement official for law enforcement purposes, including legal processes, identification and location of suspects, fugitives, material witnesses, or missing persons; information regarding victims of a crime; suspicion that death has occurred as a result of criminal conduct; evidence of criminal conduct occurring on our premises; and, in a medical emergency, reporting criminal conduct not on our premises.

Coroners, Funeral Directors, and Organ Donation: Synergy may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. Synergy may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out her duties or in reasonable anticipation of death. Finally, Synergy may use or disclose your protected health information for facilitating organ, eye, or tissue donation and transplantation.

To Avert a Serious Threat to Public Health or Safety. Consistent with applicable laws, if Synergy believes using and disclosing your protected health information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, Synergy may use and disclose your protected health information. Synergy may also disclose your protected health information if it is necessary for law enforcement to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply, Synergy may use or disclose your protected health information for activities deemed necessary by appropriate military command authorities, for determining your eligibility for benefits by the Department of Veterans Affairs, or to foreign military authority if you are a member of that foreign military service. Synergy may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation. Synergy may use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Department of Health and Human Services. As required by law, Synergy may disclose your protected health information to the Department of Health and Human Services to determine our compliance with applicable laws.

Written Authorization. Except as stated in this notice, Synergy will not use or disclose your protected health information without your written authorization. You may revoke this authorization at any time, in writing, except to the extent that Synergy has used or disclosed your information in reliance on the authorization.

Food and Drug Administration. Synergy may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance.

Inmates. Synergy may use and disclose your protected health information if you are an inmate of a correctional facility and Synergy created or received your protected health information in the course of providing care to you.

YOUR HEALTH INFORMATION RIGHTS

Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that Synergy maintains about you in our designated record set for as long as Synergy maintains that information. This designated record set includes your medical and billing records, as well as any other records Synergy uses for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial.

If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer, c/o Synergy Physicians P.L.L.C. 9070 E Desert Cove Ave, Suite #102. Synergy may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. Synergy has 30 days to respond to your request for information that LifeScape maintain at our practice sites. If the information is stored off-site, Synergy has up to 60 days to respond, but must inform you of this delay.

Request Amendment. You have the right to request that Synergy amend your protected health information. You must make this request in writing to our Privacy Officer. The request must state the reason for the amendment.

Synergy may deny your request if it is not in writing or does not state the reason for the amendment. Synergy may also deny your request if the information was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; is not part of the record which you are permitted to inspect and copy; the information is not part of our designated record; or is accurate and complete, in our opinion.

Request Restrictions. You have the right to request a restriction or limitation of how Synergy uses or disclose your protected health information for treatment, payment, or health care operations; to persons involved in your care; or for notification purposes as set forth in this notice. Although Synergy is not required to agree to your requested restriction, if Synergy does agree, Synergy will comply with your request unless the information is needed for emergency treatment. Please contact our Privacy Officer as set forth in this notice to request a restriction.

Accounting of Disclosures. You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information.

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, Synergy may charge you a fee for the costs of providing the subsequent list. Synergy will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how Synergy communicates with you to preserve your privacy. Synergy may condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our Privacy Officer. The request must specify how or where Synergy is to contact you. will accommodate all reasonable requests.

File a Complaint. You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe Synergy has violated your privacy rights. Complaints to our Privacy Officer must be in writing. Synergy will not retaliate against you for filing a complaint.

For More Information:

If you have questions or would like additional information, you may contact our Practice Administrator, 480-553-6168.

Synergy Physicians P.L.L.C.
9070 E Desert Cove Ave
Suite #A102
Scottsdale, AZ 85260
www.TheSynergyHealth.com

Effective Date: July 1, 2019

SYNERGY
PHYSICIANS

Acknowledgement of Receipt of Notice Private Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Synergy Physicians P.L.L.C. which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

_____ _____
Signature of the Patient or the Patient's Legal Representative Date

_____ _____
Print Name If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

FOR OFFICIAL USE ONLY

I, _____, made a good faith effort to obtain written acknowledgement of _____'s receipt of the Notice of Privacy Practices of Synergy Physicians P.L.LC. However, I could not obtain written acknowledgement because:

☐ Individual refused to sign this acknowledgement

☐ Communications barrier prohibited obtaining written acknowledgement

☐ An emergency situation prevented obtaining written acknowledgement

☐ Other (please specify)

_____

_____

SYNERGY
PHYSICIANS

Patient Consent to Financial Policy

THIS CONSENT CONTAINS IMPORTANT INFORMATION ABOUT BILLING AND PAYMENT FOR PROFESSIONAL SERVICES RENDERED BY SYNERGY PHYSICIANS P.L.L.C. IT OUTLINES SYNERGY'S RESPONSIBILITIES AND THOSE OF ITS PATIENTS WITH REGARD TO BILLING AND PAYMENT FOR GOODS AND SERVICES RENDERED.

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1. Synergy Physicians P.L.L.C and most of its physicians participate with many health insurance plans. The most current list of insurance selections can be found on Synergy web site and confirmed by calling our office. If the patient is a member of one of these plans and receives professional services from one of our in-network providers, Synergy will submit a claim to the plan for professional services rendered and, except as noted below, the patient will not be charged. It is the patient's responsibility to make payment at the time of service for any co-payment, co-insurance, or deductible due. **Any services not covered by a patient's insurance plan are also the patient's responsibility and payment in full is required at the time of service or denial by the insurer. Insurer delays and split claims are common and beyond Synergy's control. Consequentially, patients may be billed, in whole or in part, well after the date of service. Insurance claims unpaid or only partially paid by the patient's plan 60 days following their submission by Synergy may be billed to the patient directly with payment due upon receipt. Synergy is not a party to the patient's insurance contract and ultimate financial responsibility for services rendered lies with the patient or the patient's guarantor**.
2. If a patient is not a member of an insurance plan with which Synergy participates, including Medicare, or receives professional services from one of our out-of-network providers, **the patient must make payment in full at the time of service**. As a courtesy, Synergy will submit an insurance claim on the patient's behalf and the patient can anticipate reimbursement according to the insurer's policies.
3. Synergy provides or orders those professional services, products, tests, and referrals it believes to be in its patients' best medical interests. Synergy, however, neither guarantees nor represents that its patients' insurance plans will deem such services, products, tests, and referrals "covered" or the charges "reasonable and customary." Synergy is not responsible for its patients' insurance plans' arbitrary denials of or limits to payment.
4. It is the patient's responsibility to ensure that any authorization or referral for treatment required by his or her insurance plan is received **before their Synergy appointment**. In the absence of a required authorization or referral, the patient's visit may be rescheduled or the patient may be personally responsible for payment for the services rendered by Synergy.
5. It is the patient's responsibility to provide Synergy with current insurance information and to present an active insurance card at each visit.
6. An adult accompanying a child under age 18 and/or the parent or guardian of the child is responsible for payment according to the terms described herein. Synergy may reschedule non-emergency treatment for unaccompanied children unless charges have been pre-authorized or payment at time of service has been arranged.
7. Synergy's staff is happy to help with insurance questions relating to a filed claim or to provide reasonable additional information required by the insurance carrier to process a claim. However, patients should direct questions about coverage for specific treatments or procedures to a

representative of their insurance company's member services department. The phone number for member services is usually on the insurance card.

8. Payment for professional services may be made by cash, check, debit card, or credit card. Synergy accepts VISA®, MasterCard®, and American Express®. As a convenience, Synergy offers *Easy Pay* credit card transactions for annual administrative fees—providing a safe, secure way to pay future charges without additional billings or paperwork. *Easy Pay* enrollment forms are available at our office and on our web site.

9. Synergy charges an annual fee of fifty (50) dollars per patient; This fee helps defray the cost of non-covered administrative expenses and is due at the time care is established and annually thereafter until Synergy is notified in writing that care has been discontinued. All patients receive and are required to execute a separate Consent to Annual Fee prior to receipt of services. The foregoing not withstanding, concierge patients are exempt from annual fees for non-covered administrative expenses and are not required to execute a Consent to Annual Fee.

10. Failure to timely cancel an appointment denies Synergy the opportunity to fill that time slot and may prevent other patients from receiving the care they require. Therefore, Synergy charges a fee of $75 for appointments cancelled with less than six office hours advance notice. A patient who fails to keep three or more appointments without prior notice of cancellation may be discharged from Synergy.

11. A $25 returned item fee will be charged for each check returned or charge denied regardless of cause.

12. Interest will be charged at an annual rate of 18% on all past due patient balances.

13. Delinquent account balances may be referred to an agency for collection. All collection costs including, without limitation, attorney fees and court costs are and will remain the sole responsibility of the patient or the patient's guarantor.

14. In the event of a documented personal financial hardship, Synergy may be able to offer special financial arrangements including payment plans and waiver of select fees.

15. Patients with a past due balance may be required to pay their balance in full before additional professional services are rendered.

16. Prompt payment for services rendered is an essential element of the patient-physician relationship. Failure to promptly pay for professional services rendered or respond to communications from our office regarding payment may result in discharge from the practice.

17. Synergy reserves the right to change this financial policy in its sole discretion.

Synergy Physicians P.L.L.C.
9070 E Desert Cove Ave
Suite #A102
Scottsdale AZ, 85260
www.TheSynergyHealth.com

Effective Date: July 1, 2019

Receipt acknowledged and financial policy agreed to by:

_____ _____

Signature of the Patient or the Patient's Legal Representative | Date

_____ _____

Print Name | If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

SYNERGY
PHYSICIANS

Consent to Annual Administrative Fee

Synergy Physcians P.L.L.C. is committed to the highest level of medical care and innovative, patient-centered services. In order to meet this standard and cover the cost of a growing multitude of non-covered and excluded administrative expenses, Synergy charges an annual fee of fifty (50) dollars per patient, ages 16 and up.

This fee is due at the time care is established and annually thereafter until Synergy is notified in writing that care has been discontinued. Failure to provide payment when due may result in termination of care. Patients unable to pay due to financial hardship may contact Synergy staff to discuss other options. Synergy reserves the right to change the annual fee in its sole discretion.

Synergy administrative fee allows it to provide services not covered by insurance without levying multiple charges. Depending on your health plan, non-covered or excluded services may include, but are not necessarily limited to:

- Completion of many standard documents including Family Medical Leave Act and Return to Work forms, immunization records and school, camp and sport medical forms, pharmacy forms including change requests and special authorizations
- Medical record duplication and mailing other than as required by law
- Appointment reminders
- Internet-based appointment and prescription refill requests, health maintenance and immunization schedules, practice forms, and account statements

For your convenience, Synergy also offers these services at no additional charge:

- Near same-day appointments with the first available provider
- Extended hours and lunch hour care
- Direct, after-hours telephone access to a Synergy physician

We hope that you will find our annual fee convenient and preferable to the periodic charges that otherwise would be necessary. Your feedback is extremely important to us. Please contact us if you need further information or have suggestions for improvement.

Receipt acknowledged and annual fee agreed to by:

_____ _____

Signature of the Patient or the Patient's Legal Representative | Date

_____ _____

Print Name | If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient