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

Guarantor _____
Guarantor Employer_____
Guarantor Address_____
Guarantor Phone_____

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 for educational and learning purposes or 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 sibling policy
- ☐ I have read and understand the HIPPA act
- ☐ I understand that it is my responsibility to inform the front desk of any changes to insurance to avoid being charged for any services rendered.

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 _____

I agree to receive electronic balance statements at the following email address:

_____

_____ _____

Patient or parent signature Date