AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:______________________________________ Date of Birth:______________________

Home Phone: _________________________________ Work Phone: _____________________________

Address: ____

City/State/Zip:____

The above listed patient authorizes the following healthcare facility to make healthcare disclosure

Facility Name:____ Facility Phone:___________________

Facility Address:____

City/State/Zip:____

Dates and type of information to disclose:

2 years prior from last date seen

Dates other:____

Specific information requested:____

Reason for disclosure:

Change of insurance or physician

Continuation/continuity of care

Referral

Other:____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, 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.

This information may be disclosed and used by the following individual or organization:
Release To: Synergy Health Center Please Mail Records Please Fax Records
Address: 13020 Livingston Road, Suite 14, Naples, FL 34105, Fax: 239-263-7492 Phone: 239-263-3330

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with fully understand the terms and conditions of this authorization.

X____ ______________________________
Signature of Patient/Parent/Guardian or Authorized Representative — Date

____ ______________________________
Name of Authorized Representative — Date

synergyhealth

Patient Financial Agreement

CONSENT TO TREAT

This consent provides us with your permission to perform reasonable and necessary medical/chiropractic/physical therapy examinations, testing and treatment by the following staff: Dr. Stephanie Ahasic, DC; Dr. Benjamin Mendelsohn, MD; Dr. Christopher Ellis, DPT or Kara Corona, ARNP. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. This notice will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You also have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test or procedure recommended for you. If you have any questions or concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I have had the opportunity to discuss with the treating provider the nature and purpose of treatment and other procedures. I voluntarily request any of the above listed providers at Synergy Health to perform reasonable and necessary medical examinations, testing or treatment for the condition(s) which have brought me to seek care at Synergy Health. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including ,but not limited to fractures, disc injuries, strokes, dislocations and sprains. These risks are rare and unlikely. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, in my best interest.

I have read, and or have had read to me, the above consent. I have also had a opportunity to ask questions about its content. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire core of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: ____________________________ Date:______________

Parent/Guardian Signature:________________________ Date:______________

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (LC417A)

Disclosure of medical information: Your medical information and communication of that information is essential to your care. We prefer to speak with each patient directly but we understand that other individuals or family members may have knowledge of our be assisting in your care. Please list the individuals with whom we are allowed to discuss any aspect of your care. We can NOT discuss medical information with others including spouses or relative unless they are listed below.

Name of contact and relationship to patient:______________________ Phone #:________________

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Name of contact and relationship to patient:______________________ Phone #:________________

Patient Signature: ____________________________ Date:______________

ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICE (NPP)

I understand that Synergy Health Center may share my Protected Health Information, (PHI) for treatment, payment and healthcare operations, (TPO), and for other purposes provided by law. I have been provided a copy of Synergy Health Center's Notice of Privacy Practices that describes how my Protected Health Information is used and shared. I understand the Synergy Health Center has the right to change this nocie at nay time. I may obtain a current copy by contacting Synergy Health Center at 239-263-3330. My signature below constitutes my acknowledgement and that I have been provided with a copy of this notice of privacy practice.

Patient Signature: ____________________________ Date:______________