# First Contact & Payment Verification

| Date of Contact | Staff Name | Appt. Time | Appt. Date |
|---|---|---|---|
| | | | |

**itionCond**

| Area of pain/problem | Date pain/problem began |
|---|---|
| | |

| Mechanism of Injury | θ Work<br>θ Auto<br>θ Other | Date of similar pain/problem in past |
|---|---|---|
| Impairments? θ Sleep θ Bathroom θ Sit θ Walk θ Other: | | θ Worsening<br>θ Better<br>θ Same / θ Hospitalized<br>θ Missing work<br>Since when? |

**InfontPatie**

| Patient Name (Last, First) | Age | DOB | θ Male<br>θ Female |
|---|---|---|---|
| | | | |

| Hm Phone | Other Phone | Email |
|---|---|---|
| | | |

| Street Address | City | State & Zip |
|---|---|---|
| | | |

| How did you hear about us? | Social Security # |
|---|---|
| | |

**tionrmaInfotmenPay**

PRI WC LIEN MC AUTO SELF-PAY (discount/CC info to reserve) PAY PLAN other:

| Insurance Company Name | Referring Physician |
|---|---|
| | |

| Street Address | City | State/Zip |
|---|---|---|
| | | |

| Subscriber Name (if other than self) | θ Parent<br>θ Spouse<br>θ Other | DOB | ID # | Group # |
|---|---|---|---|---|
| | | | | |

| (WC only) Claim Number | Adjuster Name | Phone # | Date of injury |
|---|---|---|---|
| | | | |

| Employer Name | Occupation | Employer Phone |
|---|---|---|
| | | |

| Emergency Contact Name | Relationship | Emergency Contact Phone |
|---|---|---|
| | | |

| Date of Verification | Staff Name | Comments: |
|---|---|---|
| | | |

| PRI | Date of Eligibility | Copay $ | Deductible $ | Met $ | Coinsurance % | Maximums? | Notes: |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| WC | Date of Auth. | # Visits | Exp. Date | Auth # | Person Auth |
|---|---|---|---|---|---|
| | | | | | |

| Lien | Date Agreement sent | Attorney Name | Address | Date of Accident |
|---|---|---|---|---|
| | | | | |

| Auto | Third Party Name | Insurance Name | Phone # | Claim # |
|---|---|---|---|---|
| | | | | |

| Self | θ Visa<br>θ MC<br>θ Amer Ex | Name on Card | Card # | Exp Date | 3 digit code (on back) |
|---|---|---|---|---|---|
| | | | | | |

| Date of Verification | Staff Name | Comments: |
|---|---|---|
| | | |

**SYNERGY Therapeutic Group**