

SynerChi Systems Inc
APPLICATION FOR TREATMENT

DATE _____ PATIENT # _____
LAST NAME _____ FIRST _____ MIDDLE _____
MAILING ADDRESS _____
CITY _____ STATE _____ ZIP _____
STREET ADDRESS (if different) _____
HOME PHONE # (____) _____ DATE OF BIRTH ____/____/____ AGE _____
SEX _____ MARITAL STATUS: SINGLE _____ MARRIED _____
SOCIAL SECURITY # _____ Email _____
IN CASE OF EMERGENCY CONTACT: _____ PHONE # (____) _____
WHO REFERRED YOU TO US FOR CARE? _____

EMPLOYMENT INFORMATION

EMPLOYER _____
EMPLOYER ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE # (____) _____ OCCUPATION _____
FULL TIME ____ PART-TIME ____ STUDENT ____ RETIRED ____ UNEMPLOYED ____

INSURANCE INFORMATION

Person responsible for your bill? __ Self __ Spouse __ Guardian __ Employer __ Insurance __ Other
How will payment be made? _____ Cash _____ Check _____ Credit Card _____ Insurance
Name & Address of Primary Insurance Company: _____
Name of Insured Person (Subscriber): _____
Address of Subscriber (if different from patient) _____
Subscriber Date of Birth _____ Relationship to Patient (__ Spouse, __ Parent __ Other _____)
Insured Policy # _____ Subscriber ID# _____ Subscriber Group # _____
Name & Address of Secondary Insurance Company: _____

FAMILY INFORMATION

Spouse's Name: _____ Ages of Children: _____
Spouse's Employer: _____ Business Phone: (____) _____
Your nearest relative and their address: _____
May we have your permission to leave a message for you at your home? _____ Yes _____ No
May we have your permission to leave a message for you at your workplace? _____ Yes _____ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that SynerChi Systems Inc will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. This is to serve as a long term authorization card. This authorization is to apply to all occasions of service until revoked in writing.

Patient's Signature _____ **Date** _____
Guardian/Spouse Signature Authorizing Care _____ **Date** _____