Joseph Caprioli PT, DPT, MCMT
747 Wantagh Ave
Wantagh, NY 11793
P: 516-628-7700

Patient Intake Form

PATIENT NAME:			MARITAL STATUS:
EMAIL ADDRESS:			SEX: MALE / FEMALE
SOCIAL SECURITY:			STUDENT: YES / NO
DATE OF BIRTH:	AGE:	EMPLOYER:	OCCUPATION:
ADDRESS:		ADDRESS:	
CITY, STATE:	ZIP:	CITY, STATE:	ZIP:
PHONE (HOME):	CELL:	PHONE (WORK):	
EMERGENCY CONTACT:		PHONE # AND RELATIONSHIP:	
PRIMARY INS. CO:		POLICYHOLDERS NAME:	D.O.B.
ADORESS:		ID #	GROUP #
CITY, STATE:	ZIP	RELATIONSHIP TO PATIENT: SELF / SPOUSE / PARENT / GUARDIAN	
REFFERING MD:		REFERRING PHYSICIAN PHONE NUMBER:	
ADDRESS:		REFERRING PHYSICIAN FAX NUMBER	
CITY, STATE:		MAIN COMPLAINT:	
WAS AN AUTOMOBILE INVOLVED? YES NO **IF YES PLEASE ASK FOR PROPER FORMS**		WERE YOU INJURED ON THE JOB? YES NO **IF YES PLEASE ASK FOR PROPER FORMS**	
DID THIS INJURY OCCUR AT SCHOOL?		SCHOOL NAME:	
SCHOOL PHONE		SCHOOL INSURANCE CARRIER:	
SCHOOL INSURANCE ADDRESS:		DATE OF INJURY:	
HAVE YOU HAD OR ARE YOU CURRENTLY ENROLLED IN HOME HEALTHCARE: YES NO		IF YES WHEN?	

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carriers' payments. However, the patient Is responsible for all fees, co-payments and deductibles, regardless of Insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

I HEREBY AUTHORIZE THE DOCTOR TO RELEASE INFORMATION ACQUIRED DURING EXAMINATION AND/OR TREATMENT TO MY INSURANCE COMPANY AND/OR TO MY ATTORNEY.

I have read this registration form and state that all information given by me is known to be valid and true.

Patient/Guardian Signature: _____ Date: _____

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Medical History Information

Your injury is related to: Please Circle	Work Car Accident Accident Other
Injury occurred during? Please circle	Lifting/Pulling/Pushing/Falling/Bending/Unknown/Other
Onset Date:	
Surgery Date:	
Any Diagnostic tests?	Results:

Are you currently having or had problems with any below Describe if YES

Eyes, Ears, Nose	YES	NO	
Lungs (Breathing)	YES	NO	
Bowel/Bladder	YES	NO	
Diabetes	YES	NO	
High Blood Pressure	YES	NO	
Bleeding Problems	YES	NO	
Balancing	YES	NO	
Numbness/Tingling	YES	NO	
Fainting	YES	NO	
Epilepsy/Seizures	YES	NO	
Headaches	YES	NO	
Psychological Problems	YES	NO	
AIDS	YES	NO	
Cancer	YES	NO	
Arthritis	YES	NO	
Pregnant	YES	NO	
Hypoglycemia	YES	NO	
Heart Conditions	YES	NO	
Pacemaker	YES	NO	
Stroke	YES	NO	
Allergies	YES	NO	
Childhood Diseases	YES	NO	
Developmental delays	YES	NO	
Fractures	YES	NO	
Smoking	YES	NO	
Hospitalizations	YES	NO	
Surgeries	YES	NO	

Additional Information:

Please list all medications, including vitamins, you are currently taking:

Patient Name: Date:

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Insurance Waiver

INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES:

In consideration of services rendered by Joseph Caprioli PT, DPT, MCMT the undersigned patient, the undersigned promise(s) to pay to Joseph Caprioli PT, DPT, MCMT any co-pay, coinsurance or other charges required to be paid by my health insurance coverage.

ASSIGNMENT OF BENEFITS PROCEEDS:

I request that payment of authorized HMO/ third party payor/governmental agencies (Medicare and Medicaid) benefits be made either to me or on my behalf to Joseph Caprioli PT, DPT, MCMT for services furnished to me by the provider.

AUTHROIZATION TO RELEASE RECORDS:

I HEREBY AUTHORIZE Joseph Caprioli PT, DPT, MCMT to release to my insurer/HMO/third-party payor, governmental agencies, or whomever if financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

REFERRALS/CO-PAYMENTS:

HMO plans, (AETNA, CIGNA, GHI, HIP, VYTRA HEALTH PLANS, ETC): For plans requiring from the primary care physician, AUTHORIZATION MUST BE OBTAINED PRIOR TO THE TIME OF THE VISIT. Unauthorized visits will be billed to you according to the regular fee schedule. COPAYMENTS ARE DUE AT THE TIME OF VISIT. If benefits are denied due to lapsed coverage, you will be billed according to the regular fee schedule.

PRIVATE INSURANCE:

PAYMENT EXPECTED AT THE TIME OF VISIT.

Signature of Patient or Authorized Representative Date

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HIPPA

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Joseph Caprioli, PT, DPT, MCMT Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Print) Date:

_____

Signature of Patient or Authorized Representative

By signing below, I am giving Joseph Caprioli, PT, DPT, MCMT permission to discuss my treatment, appointments and financial issues with the following people:

_____

_____

_____

_____ _____

Signature of Patient or Authorized Representative Date:

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Authorization to Pay

I authorize payment from my insurance company directly to Joseph Caprioli PT, DPT, MCMT for services rendered. I understand that I am financially responsible for those charges not paid by my insurance company including deductible and co-payment. This is in accordance with the rules and regulations of my insurance company.

I am also responsible for obtaining all referrals forms, prescriptions and letters of medical necessity required in order to obtain services in this facility

Patient's Name: _____

Patient's Signature: _____

Parent or Guardians Signature: _____
(If patient is under 18 years of age)

Physical Therapy Specialists

Physical Therapy Specialists are committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at 516-628-7700 a minimum of 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office on Friday.

If prior notification is not given, you will be charged $25 for the missed appointment.

Please sign below to consent to these terms.

Patient Signature (Patient's Parent/Guardian if under 18)