Capital Area Physical Therapy & Wellness New Patient Intake Form

Contact Information:

Name: (First)	(Last)	(MI)	Name you prefer:
Address:	Apt #:	City:	State: Zip:
Email Address: Can we contact you via email (circle one)? Yes No		Cell Phone number:	
Birth Date: / / Age:	Sex: M / F	Employer:	Job Title:
Are you working? Y / N	If no, is it because of your problem? Y / N	Emergency Contact:	
Emergency Contact Relation:	Emergency contact phone number:		Marital Status: M S D W
Whom may we thank for your referral?	☐ Referring Physician ☐ Family/Friend:______________	☐ Website	☐ Social media:______________ ☐ Other:______________
Referring Physician:		Primary Care Physician:	

Cancellation/No Show Policy, Agreement for Payment and Co-payment

At Capital Area PhysicalTherapy and Wellness, we offer a unique physical therapy experience where there is a one on one approach and we strive to keep you with the same therapist throughout your time here. Our goal is to provide the best possible care while are you here. To help us achieve this goal, please be aware that there is a $25.00 charge for not showing up for your scheduled appointment, or for all cancellations with less than 24 hour notice. Please also be aware that any payments for self pay/co-payment are due at the time of the services rendered. You may also be responsible for any balances/co-insurances due after insurance payment is made (i.e. deductible). Please also be advised that it is your responsibility to notify us promptly of any changes in your insurance plan to allow accurate billing for services

In order to better serve you, we may contact you to remind you of your scheduled appointments. How would you like to be reminded of future appointments (circle one or more)? Phone call Text Appointment cards

**I accept financial responsibility if my Workers Comp/No Fault or primary insurance denies treatment

______________________________ ______________________
Patient Signature Date

____
Patient Printed Name

______________________________ ______________________
Parent or Guardian Signature (if under 18) Date

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Parent or Guardian Printed Name

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Patient's Certification, Authorization to Release Information and Payment Request(**HIPAA**)

Release of Medical Information:

I hereby authorize the release of any necessary and pertinent information to my insurance company of their representative for the payment of my insurance claim for services rendered at Capital Area Physical Therapy, PLLC. If another provider who is involved with treatment, payment, of health care operations relating to me requests my medical records, or if deemed advisable by the treating clinician, I consent to the release of my entire medical records maintained by the provider to those other providers. I also give consent for Capital Area Physical Therapy, PLLC to use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care operations. I agree, as part of this consent for payment operations, that Capital Area Physical Therapy, PLLC can disclose billing information to any identity of the calling person and the calling person provides my correct social security number or health plan number.

Permission to Discuss Protected Health Information ("PHI") with Third Persons

I agree that the provider may discuss my PHI with any persons that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person(s). I also agree the provider may discuss my PHI with any employers who arrange pay, directly or indirectly, for my medical treatment.

Permission to Discuss Health Information Regarding Minors

I agree that Capital Area Physical Therapy, PLLC may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents/stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI and that I have no right to receive this information.

Assignment of Benefits

I authorize my insurance carrier to pay the claim the series rendered directly to the provider, namely Capital Area Physical Therapy, PLLC (DBA "Capital Area Physical Therapy and Wellness") 7 Hemphill Place Suite 130 Malta NY 12020.

I authorize release of any information needed to act on this request, and request that payment of authorized benefits be made on my behalf

Permission to Call and Leave Voice Mail/Data Messages/Electronic Mail Correspondence

I agree that Capital Area Physical Therapy, PLLC may call and leave a voice mail and/or data message at my home or other number I provide them, or correspond to the electronic mail address I provide them regarding medical appointments, billing, or payment issues, or other information related to treatment, payment or health care operations. I may choose a preferred method of contact and alert this to the provider/staff.

Notice of Privacy Practices:

I am aware that, upon my request, I can receive a copy of "Notice of Privacy Practices" which sets forth this provider's privacy practices and my right regarding privacy of my PHI upon request

This serves as the paper copy of this notice. The patient makes the following special requests for confidential comminications:

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Patient Signature:______________________________ Date:________________

Patient Medical History

The following form will help us to better serve your current needs and overall wellness. If you have any questions of need any assistance, please ask our staff.

Name:_______________________________ **Reason for today's visit**____________________________________

Have you been seen by a Doctor or other health care provider for your current problem: Yes_____ No_____

MD/Physician____ Dentist____ Orthopedic____ Neurologist/Neurosurgeon____ Podiatrist____ Osteopath/DO____

When are you going back to be seen for your current problem:____

Have you had any of the following performed (Please check all boxes that apply. Unmarked boxes will be understood as no)

X-rays____ CT scan____ MRI____ Bone Scan____ Blood Work____ Ultrasound____ Other____

If yes, please explain:____

Have you had any of the following for your CURRENT problem:

Home Care____ Physical/Occupational Therapy____ Chiropractor____ Injections ____ Surgery____

If yes, please explain (Please include dates):____

Current Medications: If you have a copy of your current medication list, please write "see copy" and provide it to the front staff

____

Do you have any allergies: Yes_____ No_____ If yes, please explain:_____________________________________

Height:__________ **Weight:**__________

Women: Are you pregnant or may be pregnant? Yes_____ No_____

Please check all of the following that apply in regards to you overall health			**Explain all YES answers on the line**
Arthritis	Yes____	No____	______________________________
Asthma	Yes____	No____	______________________________
Heart/Cardiac Dysfunction	Yes____	No____	______________________________
Stroke/Brain Aneurysm	Yes____	No____	______________________________
Diabetes	Yes____	No____	______________________________
High Blood Pressure	Yes____	No____	______________________________
Seizure Disorder/Epilepsy/Fainting	Yes____	No____	______________________________
Cancer	Yes____	No____	______________________________
Vision or Hearing Dysfunction	Yes____	No____	______________________________
Other	Yes____	No____	______________________________