# MASEFIELD & CAVALLARO PHYSICAL THERAPY – Medical Intake Form

**Patient Name:**_____**DOB**_____**Date**_____

**MEDICAL HISTORY**

**RIGHT / LEFT HANDED** **MALE / FEMALE**

**128**

**Height** _____ **Weight** _____

**What is the problem you are here for?**_____

_____

**Date of injury or when pain started?** _____

_____

**Date of Surgery (if applicable)**_____

**Check which apply to your injury**

- [ ] Work-related
- [ ] Motor Vehicle Accident
- [ ] Athletic / recreational injury
- [ ] Injury related to lifting or falling
- [ ] Reoccurrence of previous injury
- [ ] Result of a Fall
- [ ] Other: _____

**Is this your first time you have had this problem? YES / NO**

**If No, then when?** _____

**What treatments have you tried? Medications Massage**

**Physical Therapy Chiropractic Surgery**

**Did you complete Medication List? (130) YES / NO**

**PAIN AND SYMPTOMS (131) Circle the Answer**

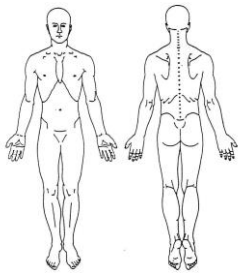
**Is your pain? Occasional Continuous**

**Circle the answer that rates your pain, right now 1 2 3 4 5 6 7 8 9 10**

**Circle the answer that rates your pain, at worst 1 2 3 4 5 6 7 8 9 10**

**Circle the answer that rates your pain, at best 1 2 3 4 5 6 7 8 9 10**

**Please identify the location of symptoms**



**FALLS ASSESSMENT (154/155) Circle Answer**

**Is your injury a result of a fall? YES / NO**

**Did you fall INSIDE or OUTSIDE your home?**

**Have you had 2 or more falls this year? YES / NO**

**Do you use an assist device? CANE / WALKER / CRUTCHES**

**Do you take Vitamin D supplements? YES / NO**

**Do you wear glasses? YES / NO**

**Did you have an eye exam this year? YES / NO**

**SOCIAL HISTORY**

**Do you smoke? YES / NO** **Drink Alcohol? YES / NO**

**Married? YES / NO** **Children? YES / NO**

**Do you regularly exercise? YES / NO**

**WORK HISTORY**

**Are you employed? YES / NO**

**Are you presently working? YES / NO**

**If No, then date of last work day?**_____

**Current Occupation?** _____

**PAST MEDICAL HISTORY Check which apply**

| | |
|---|---|
| [ ] Asthma | [ ] Defibrillator |
| [ ] Emphysema | [ ] Stroke |
| [ ] Diabetes | [ ] Arthritis |
| [ ] Cancer | [ ] Osteoporosis |
| [ ] Heart Disease | [ ] Metal Implants |
| [ ] High Blood Pressure | [ ] Joint Replacements |
| [ ] Pacemaker | [ ] Seizure Disorder |

[ ] Allergies (Food, Medications, Latex, Lotions, Tape)

[ ] Other _____ _

**If FEMALE, Are you pregnant? YES / NO**

**PAST SURGICAL HISTORY Indicate Surgeries and date/year**

_____

_____

**Check which apply:**

| | |
|---|---|
| [ ] Chest Pain | [ ] Fatigue |
| [ ] Shortness of Breath | [ ] Balance Problems |
| [ ] Change in bathroom habits | [ ] Vision Problems |
| [ ] Significant Weight loss/gain | [ ] Swelling hands/feet |
| [ ] Headaches | [ ] Dizziness |
| [ ] Fainting | [ ] Difficulty Sleeping |
| [ ] Other | [ ] Pain at night |

_____

**Any other important information:**

_____

_____

***No Medications** _____ **Initial**

MASEFIELD & CAVALLARO

Physical Therapy, PC

7608 15th Avenue Brooklyn, NY 11228 Tel: 718-259-0900 Fax: 718-232-5048
69 Guyon Avenue Staten Island, NY 10306 Tel: 718-979-7013 Fax: 718-980-2868

**Please list all Medications , Vitamins & Supplements you are currently taking.**

| Name /Dose | Frequency (oral or injected) | Route Administered |
|---|---|---|
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Patient Name :_____

Date of Birth:_____

Date:_____

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# CONFIDENTIAL PATIENT INFORMATION

Name: _____Date: _____

Permanent Mailing Address: _____
(city) (state) (zip)

Home Phone: _____ -_____- _____Work/cell: _____ -_____- _____ Email:_____

DOB: _____ /____ / _____ Age: _____ SS #: _____ -_____-_____ Are you Medicare Eligible YES____NO _____

Marital status: Single ____ Married ____ Divorced ____ Separated ___ Widowed ____

Occupation: _____ Employer: _____

Employment Status (circle one) FT PT Retired Not Working Disability Student

Dr. Referring you for Physical Therapy:_____Phone_____

Primary Care Provider _____Phone_____

Date of (circle one) INJURY / CONDITION / ACCIDENT Date of Surgery:_____

In case of emergency (Name/relationship)_____Phone Number _____

Who can we thank for referring you to our facility? _____

## Consent for treatment

I hereby authorize the staff of Masefield-Cavallaro Physical Therapy PC to provide physical therapy evaluation and treatment. The plan for treatment will be based upon the findings of the evaluation. I will be advised of the findings of the evaluation and plan of care at the completion of the evaluation. I authorize consent for treatment and acknowledge that no guarantees or assurances have been made to me concerning the resulting outcome of treatment.

_____ _____

Signature of Patient or Personal Representative Date

**Name:**____________________________________________ **Date:**________________

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## Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

By signing below, I acknowledge that I have access to and at my request I may be provided a copy of the Masefield-Cavallaro Physical Therapy, P.C. (MCPT) Privacy Practices and how health information may be used and disclosed by MCPT, P.C. and other entities listed in the beginning of the HIPPA policy. I may obtain access to and control this information. I also acknowledge that The Practice may use and disclose information to treat me and arrange for my medical care, to seek and receive payment of services given to me, and for the business operation of The Practice, its staff, and the facilities listed at the beginning of the notice.

**X**________________________________________ ________________________
*Signature of Patient or Personal Representative* *Date*

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## Release of Information

I authorize the release of any information concerning my health and health care services to MCPT, PC relevant to my care, from my physician, health care provider or diagnostic testing facility.

**X** ____________________________________ ______________________
*Signature of Patient or Personal Representative* *Date*

••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••••

## Authorization of Payment

We accept assignment of insurance benefits. Our Financial Policy requires payment in full of any balance billed to you by our facility within 30 days of receiving a statement. Your insurance policy is a contract between you and your insurance company. If you're insurance company has not paid your account in full within 45 days you will be responsible for the balance on the account. You are responsible for providing any/all changes to your policy including cancellations or new policy coverage and benefits.
In the instance that our charges go towards meeting your yearly deductible, this deductible amount will be billed to you and payable within 30 days of receipt of statement.

**X** Signed:________________________________________ Date:______________________

I authorize payment of medical benefits to MCPT, PC for all services rendered by MCPT, PC. I hereby authorize my insurance company to make payment directly to MCPT I authorize the release of any information concerning my health and health care services MCPT, PC to my insurance company, pre-paid health plan or Medicare as required to receive payment for services rendered.

**X** Signed:________________________________________ Date:______________________

Auto insurance companies cover physical therapy benefits as long as there is Personal Injury Protection (PIP) coverage available. MCPT will verify if PIP coverage is available on your policy. If your policy has a deductible you will be responsible for payment at initial evaluation. Any charges that exceed your policy PIP limit will be your personal responsibility. We accept cash, checks, VISA, MasterCard, Discover, AMEX and all HSA cards with a credit card logo. We do understand that patients may experience financial problems occasionally. If you need to arrange a payment plan, please contact our Billing Manager at (718)234-8984. Unfortunately we do not accept liens in lieu of payment.

**X** Signed:________________________________________ Date:______________________

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# NEW YORK MOTOR VECHICLE NO-FAULT INSURANCE LAW
# ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor') hereby assign to Masefield-Cavallaro Physical Therapy, PC, ("Assignee"). all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled Under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _____, not withstanding any other agreement to the contrary.
( Accident date)

In consideration of services rendered or to be rendered, I hereby assign to the provider of the services and/or his assignees so much of my first party No-Fault automobile insurance benefits and rights; attendant thereto, shall equal the full amount of the bill for such service and the provider of his assign may secure same in my name. I further understand if said sum is not collected I will remain personally liable therefore.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ (Print name of Patient)

_____ (Signature of Patient)

_____

_____ (Date of signature)

_____ (Address of Patient)

_____ (Signature of Provider)

_____ (Date of signature)

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# No-Show and Cancellation Policy

It is our goal to provide you with individualized and goal oriented treatment. In order to accomplish this, we ask that you be compliant with your scheduled appointment. We understand that certain circumstances cannot be anticipated, and will require cancellation. In General our office policy is to charge a fee for missed or same day cancellation of appointments.

- Visits that are **cancelled the same day** will be subject to a **$25.00** cancellation fee.
- **No- show** for a scheduled appointment is subject to a **$50.00** cancellation fee and **cannot be waived**
- **If you are running late please call us. If we call you it is considered a no show and you will be charged**
- Lateness, if you arrive more than 20 minutes late for your scheduled appointment we reserve the right to reschedule your appointment for a later date or available time.
- There are a number of ways to avoid a cancellation fee from a same day cancellation/no show
    - By providing us with your email and cell provider you allow us to remind you of your appointments*
    - You can respond to these reminders should something unexpected come up the night before
    - Leave a message on the machine before midnight the night before

It is our goal to provide all our patients with individualized, comprehensive care. Please help us serve you better by keeping your scheduled appointment and be attentive in the sessions.**

Joy Masefield, PT, RN

Vincent Cavallaro, PT

Patient Name: _____ Date: _____

* **WE DO NOT SHARE EMAIL ADDRESSES WITH ANY THIRD-PARTY-** IT'S ONLY USED TO COMMUNICATE WITH YOU FOR EFFECTIVE AND CONSISTENT TREATMENT AND THE SERVICES WE PROVIDE FOR SAID TREATMENT

** AS A COURTESY TO STAFF AND PATIENTS WE DISCOURAGE USE OF CELLULAR PHONES IN TREATMENT AREAS AND PUBLIC SPACES. USE OF CELLPHONES IS PROHIBITED WHILE ON THE MACHINERY



Please Turn Over →