New Patient Intake Form

NAVESINK REHAB
225 HWY 35 NORTH, SUITE 205
RED BANK, NJ 07701

PATIENT INFORMATION (Please print)			
Patient Name		Date of Birth	Age
Address	City	State	Zip
Phone	Work	Cell	
Social Security Number	Sex: Male ___ Female ___	Marital Status: Single___ Married___ Divorced ___ Widowed___	
Occupation	Text or Email Appointment Reminders: Y/N	Cell Carrier:	Email Address:
Emergency Contact & Relationship	Phone		
Website referral or who referred you?			

INSURANCE INFORMATION			
PRIMARY INSURANCE			
Name of Insurance Company		HSA Acct: Y / N	
Address			
Policy #	Group #		
Subscriber Name & Relation	D.O.B		
Subscriber SS #			
SECONDARY INSURANCE			
Name of Insurance Company		HSA Acct: Y / N	
Address			
Policy #	Group #		
Subscriber Name & Relation	D.O.B		
Subscriber SS #			

I, undersigned, authorize payment of medical benefits to NAVESINK REHAB for any service furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize you to release to my insurance company or their agent, information concerning health care, treatment, or supply provided to me. This information will be used for purpose of evaluating and administering claims benefits.

Patient Signature _____ Date _____

PATIENT NAME

List of chief complaints in order of severity: **Pain Scale:**

1. _____ /10 For how long: _____
2. _____ /10 For how long: _____
3. _____ /10 For how long: _____

If you have pain, does it travel? Yes No
If yes: where? _____

Circle any activities that *aggravate* the condition:

Walking Lifting Coughing Sitting Bending Sneezing Sleeping Other

Circle any activities that *alleviate* the condition:

Rest Standing Heat Exercise Lying Down Ice Sitting Massage Other

Do you currently have, or have you had any of the following condition or symptoms?

__Headaches	__Fatigue	__Loss of balance	__Shoulder pain
__Knee pain	__Vertigo	__Nervousness	__Neck pain
__High Blood Pressure	__Wrist of hand pain	__Cancer	__Low back pain
__Shortness of Breath	__Chest pain	__HIV	__Other
__Loss of smell/taste	__Heart condition	__Dizziness	_____
__Numbness or tingling	__Stomach problems	__Depression	_____
__Hip pain	__Ringing in ears	__Anxiety	_____

List your hospitalizations, operation, and/or serious illness:

_____

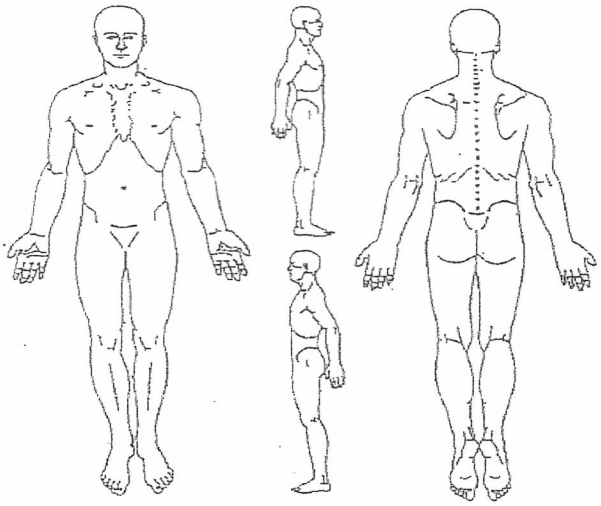
_____

List all the medications you are currently taking:

_____

_____

Indicate on the diagram where your pain is:



Capule, LLC

Navesink Rehab

225 Hwy 35 N, Suite 205

Red Bank, NJ 07701

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

To use or disclose the following health information.

☐ All of my health information

☐ My health information relating to the following treatment or condition:
_____

☐ My health information covering the period of healthcare from (date) _____ to (date)_____

☐ Other: _____

The above party may disclose this health information to the following recipient:

Navesink Rehab

Address: 225 Hwy 35 N, # 205, NJ 07701 Phone: 732.530.7700 Fax: 732.530.7701

The purpose of this authorization is (check all that apply):

☐ At my request
☐ Other: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
I understand that uses and disclosures already made based upon my original permission cannot be taken back.
I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____

Date: _____

If the patient is a minor or unable to sign please complete the following:

☐ Patient is a minor: _____ years of age

☐ Patient is unable to sign because:
_____

Signature of Authorized Representative:
_____

Date: _____

Print Name of Authorized Representative:
_____

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other:

_____

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Missed Appointment and Cancellation Policy

Our goal is to provide quality individualized medical care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. Please be courteous and call the office promptly if you are unable to show up for an appointment. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Scheduled Appointments

We understand that delays can happen. If you are running 15 minutes past your scheduled appointment and we do not receive a phone call advising the office accordingly - we may need to reschedule your appointment.

Patient Signature Date

Staff Signature Date

FINANCIAL POLICY

Capule, LLC
Navesink Rehab
225 Hwy 35 N, Suite 205
Red Bank, NJ 07701

FINANCIAL POLICY

Thank you for choosing us to provide you with medical care. We are committed to serving you with skill and care. The medical services by our office are services you have elected to receive which may result to a financial responsibility on your part.

CO-PAYS: Co-pays are due at the time of service.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

PROOF OF INSURANCE: We require copies of your driver's license and current insurance card. If a current insurance card is not present, payment in full is required until insurance coverage can be verified.

MEDICARE: We are a participating Medicare provider. Medicare as well your secondary insurance (if any) will be billed for you. You are responsible for co-insurance and/or deductible amounts as stated by Medicare and your secondary insurance company.

PRIMARY INSURANCE: We may or may not be a participating provider for your insurance company. Your primary as well as your secondary insurance (if any) will be billed for you. You are responsible for co-payment for deductible amounts as stated by your insurance companies.

NON-COVERED SERVICES: Some services may not be covered or not considered reasonable/necessary by your insurance. Please contact your insurance company with any questions regarding coverage.

PATIENT BILLING: A statement of your financial responsibility (co-insurance, deductible) will be sent to you after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. You will be sent up to two notices. The first statement gives you 21 days to send payment. The second and last notice give you an additional 10 days. Your account may be forwarded to collections, thereafter. Please let the billing office know if you any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check, Money Order, and Credit Cards.

An additional $35.00 will be added to your statement if the check is returned for insufficient funds.

In the event that your insurance company should happen to send payment to you, we expect that you would forward it to our office to be applied to your balance.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

I have read the above policy regarding my financial responsibility to Capule, LLC for providing medical services to me or the below named patient. I agree to pay any amount due after payment has been made by my insurance carrier and any contractual adjustments have been credited **OR** the full amount of all bills incurred by me or my dependent if there is no health insurance coverage exists.

PRINT Patient Name: _____ Signature: _____

FINANCIAL RESPONSIBILITY PARTY:

PRINT Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____