Joseph J. Valerio MSPT
Victoria A. Valerio MSPT

Date:__________________

Patient Name ____

Soc. Sec. No.______________________ Date of Birth ____________________

Address ______________________ Home Phone ____________________

City ______________________ Cell Phone ____________________

State______________________Zip ____________________

E-mail Address ____

Referring Doctor/Phone # ____________________________________

Primary Doctor/Phone #______________________________________

Patient's Employer____

Party Responsible for Payment: ☐Self ☐Spouse ☐Parent

Primary Insurance Carrier ____________________________________

Subscriber's Name ____________________ ID#____________________

Subscriber's Date of Birth ________________

Secondary Insurance Carrier ____________________________________

Subscriber's Name ____________________ ID#____________________

How Did You Hear of Our Office? ______________________________

Worker's Compensation

Carrier's Name ____________________ Carrier Case # ________________

Date of Injury______________________ WCB Case # ________________

Employer at Time of Accident ________________________________

Employer Address and Phone ________________________________

No-Fault

Carrier's Name ____________________ Claim # ____________________

Date of Accident_____________ Policy Holder's Name ________________

Policy # ________________ Contact Name and # ____________________

484 Hawkins Avenue • Lake Ronkonkoma, New York 11779
Tel: (631) 467-4221 • Fax: (631) 467-4233 • E-Mail: JValerioPT@aol.com

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Victoria A. Valerio MSPT

Authorization and Consent

I hereby consent to all evaluation and treatment to be provided by the Physical Therapist, as deemed necessary.

- ✓ Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery. To better serve you, we ask that all patients call to cancel scheduled appointments.
- ✓ Excessive lateness with failure to notify our office infringes on your fellow patients scheduled time. We reserve the right to limit services.

I hereby authorize the release of all information regarding my medical history, findings and treatments to this office, my physician and any third party payers.

I hereby authorize payment directly to this office for professional services rendered and shall be personally responsible for any deductible co-insurance payment and unpaid balance after insurance reimbursement.

SIGNATURE: ____

PRINTED NAME: ____

DATE: ____

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HIPAA REGULATIONS

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. **We will not use or disclose any medical information for reasons not listed below without specific written authorization from you.**

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved with your care. We may also share medical information about you to your other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any questions about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

Your signature below indicates your understanding of and compliance with the above privacy practices.

_______________________________________ _____________________

Printed Name Date

____

Signature

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