LINCOLN ORTHOPEDIC PHYSICAL THERAPY, P.C.

Today's Date:

PATIENT INFORMATION

Date of Birth:	Last Name:	First Name:
Preferred Name:	Middle Name:	SSN:
Gender: Male / Female	Employer:	
Patient Mailing Address:	City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:
Email:	Would you like appointment reminders? ☐ No ☐ Yes – cell phone provider:	

EMERGENCY CONTACT INFORMATION

Name:	Relationship:	Phone:

INJURY INFORMATION

Have you received any Speech, Occupational, or Physical Therapy this year? ☐Y /☐N

Have you recently received or are you currently receiving home health care? ☐Y /☐N

What are we seeing you for today?	Date of Injury:

Is this related to a Work or Auto accident? ☐Y /☐N If yes: ☐Work ☐ Auto State of Accident:

Referring Physician:	Surgery Date:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:

ID#:	**GROUP#:**

Subscriber Name:	Date of Birth:	Relationship:

Subscriber Address (if different from the patient):

SECONDARY INSURANCE NAME:

ID#:	**GROUP#:**

Subscriber Name:	Date of Birth:	Relationship:

Subscriber Address (if different from the patient):

GUARANTOR INFORMATION (person to receive billing statements)

Guarantor Name:	Date of Birth:	Relationship:

Guarantor Address:

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PERSONAL HEALTH HISTORY

Patient Name:	Date:
Height:	Weight:

Was this injury treated in the Emergency Room? ☐ Y / ☐ N Treatment Location:

Have you had X-rays or MRI's taken? ☐ Y / ☐ N Imaging Location:

Do you smoke? ☐ Y / ☐ N How many packs per day?

Alcohol use ☐ Never ☐ Occasionally ☐ Frequently

MEDICAL HISTORY

Allergies	☐ Yes ☐ No	Depression	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Dizzy Spells	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Emphysema/Bronchitis	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Gallbladder Problems	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Strokes	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulation Problems	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No	HIV	☐ Yes ☐ No

Describe any other conditions or precautions:

FALLS HISTORY

Have you had an injury because of a fall in the last year? ☐ Y / ☐ N

Have you had two or more falls in the last year? ☐ Y / ☐ N

SURGICAL HISTORY

Body Region:	Date of Surgery:
Body Region:	Date of Surgery:
Body Region:	Date of Surgery:
Body Region:	Date of Surgery:

CURRENT MEDICATIONS

Drug:	Dosage:
Drug:	Dosage:
Drug:	Dosage:
Drug:	Dosage:
Drug:	Dosage:
Drug:	Dosage:
Drug:	Dosage:
Drug:	Dosage:

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Patient Name:

HIPAA PRIVACY RELEASE

I give permission to Lincoln Orthopedic Physical Therapy, P.C. to discuss my treatment and/or billing/insurance information with the following people: _____

_____

ASSIGNMENT OF BENEFITS / CONSENT TO TREAT

I, the undersigned, hereby assign and set over to Lincoln Orthopedic Physical Therapy, P.C., all claims, damages and causes of action for the sum arising out of any accident creating the need for me to have therapy services, to the extent of any unpaid balance due to Lincoln Orthopedic Physical Therapy, P.C. for therapy services. I understand this assignment DOES NOT relieve me of any obligation to pay Lincoln Orthopedic Physical Therapy, P.C. myself. I authorize for payment of insurance benefits to be made directly to Lincoln Orthopedic Physical Therapy, P.C. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I authorize any information pertaining to any medical claim, grievance, or appeal, including any external review rights, filed by Lincoln Orthopedic Physical Therapy, P.C. on my behalf be released or received by Lincoln Orthopedic Physical Therapy, P.C. I authorize Lincoln Orthopedic Physical Therapy, P.C. to act as my Authorized Representative regarding claims, grievances and appeals for services rendered by Lincoln Orthopedic Physical Therapy, P.C. for as long as I, or the patient, is treated at, or have outstanding claims with, Lincoln Orthopedic Physical Therapy, P.C. I, the undersigned, authorize the release of any information necessary to process this claim.

I understand that by signing below I am giving permission to be evaluated and treated by Lincoln Orthopedic Physical Therapy, P.C. and that I have the right to refuse any procedures after having the risks and benefits explained to me.

I certify that the information I have given is true and correct to the best of my knowledge. I will notify Lincoln Orthopedic Physical Therapy, P.C. of any changes in my health status or the personal information. I have been offered a copy of Lincoln Orthopedic Physical Therapy, P.C.'s Notice of Privacy Practices.

Signature: _____ **Date:** _____

FINANCIAL AGREEMENT

Payment is due in full upon receipt of each monthly billing statement. All amounts not paid within 30 days following the date of billing are considered past due. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account and for any professional services rendered and accumulating interest charges. I understand that the minimum monthly payment requirement is $50 and that my balance must be paid in full within 10 months. In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I authorize Lincoln Orthopedic Physical Therapy, P.C. to release all information to insurance companies, attorneys, or other physicians to secure the payment of benefits. **Initial:** _____

VISIT LIMITATIONS / SUPPLIES

I understand that my insurance policy is a direct contract between myself and the insurance company. I understand that my insurance policy may have visit limitations and that as a courtesy, Lincoln Orthopedic Physical Therapy, P.C. will track the visits I have here. However, Lincoln Orthopedic Physical Therapy, P.C. is unable to track any visits used at any other facility. I understand that I am responsible for any visits that exceed my covered limit. I also understand that if my health insurance carrier does not cover a supply, I am responsible in full for the cost of the supply I received. **Initial:** _____

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