Lincoln Orthopedic Physical Therapy

How did you find out about Lincoln Orthopedic Physical Therapy?
☐ **Past patient/Friend or family** ☐ **Physician Only** ☐ **Google/Social Media/Website**
☐ **Location/Street sign** ☐ **Attorney/Nurse Case Manager/Insurance**

Patient Information

Today's Date _____/_____/_____

Name_____ _____
First *Middle* *Last* Name you use

Address_____

City_____ State_____ Zip_____

Email _____ Sex ☐ Male ☐ Female

Main Phone(____)_____Work Phone(____)_____Other Phone(____)_____

Date of Birth _____/_____/_____ Social Security Number _____/_____/_____

Referring Physician Name_____ Date of Injury _____/_____/_____

Employer_____ Job Title_____

Address_____

City_____ State_____ Zip_____

Is this claim covered by: Worker's Compensation ☐Yes ☐No or from a Motor Vehicle Accident? ☐Yes ☐No

Have you recently received or are currently receiving home health care? ☐Yes ☐No

Primary Insurance _____Policy Holder (insured)_____

Birth date of insured _____/_____/_____Patient relationship to insured _____

ID Number _____ Group Number_____

Secondary Insurance _____Policy Holder (insured)_____

Birth date of insured _____/_____/_____Patient relationship to insured _____

ID Number _____ Group Number_____

Guardian/Guarantor

If the Guarantor (person to receive billing statements) is different from the patient, please complete below:

Name_____

Address_____

City_____ State_____ Zip_____ Telephone (_____)_____

Emergency Contacts

Name: _____

Relationship_____ Telephone (_____)_____

Name: _____

Relationship_____ Telephone (_____)_____

Personal Health History

Patient Name _____ Date_____/_____/_____

Height _____ ft _____ in Weight _____ pounds

Was this injury treated in the Emergency Room? ☐ Yes ☐ No Treatment Location_____

Have you had X-rays or MRI's taken? ☐ Yes ☐ No Imaging Location_____

Have you or will you be having surgery? ☐ Yes ☐ No Date of Surgery____/____/_____

Location of Surgery: _____

Do you smoke? ☐ Yes ☐ No **If "Yes"** 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 as a result of a fall in the last year? ☐ Yes ☐ No

Have you had two or more falls in the last year? ☐ Yes ☐ No

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 _____

Attorney Information

Do you have an attorney representing you? ☐Yes ☐No

Attorney's Name_____

Attorney's Address_____ Suite #_____

City_____ State_____ Zip_____ Telephone (_____)_____

HIPAA Privacy Release

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

Please Read This Information and Sign Statement Below

Payment is due in full upon receipt of each monthly billing statement. All amounts not paid within 30 days following 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 for any professional services rendered and accumulated interest charges.

I, the undersigned, hereby assign and set over to LINCOLN ORTHOPEDIC PHYSICAL THERAPY, P.C., all claims, damages and causes of action for the same arising out of any accident creating the need for me to have physical therapy services, to the extent of any unpaid balance due to LINCOLN ORTHOPEDIC PHYSICAL THERAPY, P.C. for physical therapy services. I understand this assignment DOES NOT relieve me of any obligation to pay LINCOLN ORTHOPEDIC PHYSICAL THERAPY, P.C. myself.

I understand that by signing I am giving permission for evaluation and treatment 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 you of any changes in my health status or the personal information I have given. I have been given a copy of Lincoln Orthopedic Physical Therapy's Notice of Privacy Practices. I, the undersigned, authorize the release of any information necessary to process this claim.

Signature_____Date_____/_____/_____

Medicare Coverage

I have been informed of Medicare coverage and limitations.

Signature_____Date_____/_____/_____

Medicaid Coverage

I have been informed of Medicaid coverage requirements.

Signature_____Date_____/_____/_____

OMB No. 0938-0124

Medicare Secondary Payer Questionnaire

(Required for All Medicare patients)

Name _____ Date of Service _____/_____/_____

	YES	NO
1. Are you a Veteran?	☐	☐
a. Did the VA refer you here for treatment?	☐	☐
b. Do you have a VA "fee basis" ID card?	☐	☐
2. Do you have a Federal Black Lung card?	☐	☐
3. Is this medical condition due to an accident of any kind?	☐	☐
If yes, was it: ☐ Work related ☐ Auto related ☐ Injury in own home ☐ Other_____		
4. Are you covered by an employer's health insurance plan through your own employer or that of a family member? (Does not include retiree coverage)	☐	☐
5. Have you recently received or are currently receiving home health care for any reason?	☐	☐
If yes, With whom _____ When _____		
6. Have you recently received or are currently receiving physical therapy with any other company?	☐	☐
If yes, With whom _____ When _____		

Signature_____Date_____/_____/___

Worker's Compensation Claim Information

*We will bill your worker's compensation insurance company for all charges incurred, if you provide us with the information requested below. All lines in **bold** print are **required**. Failure to provide this information may result in bills being sent directly to you.*

Patient Name _____

Has your claim been accepted by Work Comp Insurance? □ Yes □ No □ Pending

Employer Name_____

Human Resources Contact _____ Phone # (___)_____

Work Comp Insurance Company Name_____

Billing Address_____

City _____ State_____ Zip_____

Claim or Case #_____

Date of injury____/_____/____

Insurance Adjuster Name_____ _____

Phone# (____)_____ Fax # (____)_____

Nurse Case Manager Name_____

Phone# (____)_____ Fax # (____)_____

If my claim is not accepted or paid by the worker's compensation insurance company, I understand that I am financially responsible for all charges rendered by Lincoln Orthopedic Physical Therapy.

Signature_____ **Date**____/_____/____