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 (______)_________________

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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

Condition		Condition		Condition	
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 ________________________

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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_______/_______/_______

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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_______/_______/___

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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____/_____/____

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Motor Vehicle Accident Information

Our MVA policy is as follows:

1. We will first submit your claims directly to your Auto Insurance's Med Pay as your claims will be paid in full by your Med Pay until benefits are exhausted. Please note: If your private health insurance is through **Blue Cross Blue Shield**, we are bound by contract to bill them first, without exception.

2. Once your Med Pay has been exhausted, we will bill your private health insurance. Copays are due at time of service, and you are obligated to pay your deductible and/or out of pocket balances as per your policy terms. Please Note: If your insurance coverage is issued by the government (**Medicare or Medicaid)** and you are not the liable at fault party, we are required to bill the 3rd party insurance, as government dollars cannot be used when another party is liable.

3. As a last resort, if your Med Pay **and** private health insurance benefits are exhausted, we will bill the liable 3rd party. **In this case, you are required to pay $50 at the beginning of each appointment.** Once your case has settled, these payments will be reimbursed to you by the 3rd party insurance.

I understand the policy stated above. I understand that I am ultimately responsible for the balance on my account for any professional services rendered.

SIGNATURE____ DATE___________________

(Parent or Guardian signature if patient is a minor)

All bolded fields are required, failure to provide this information may result in you being billed directly.

Date of Accident ______/_______/_______

Your Auto Insurance Company Name____

Claim #_______________________________ Policy # _____________________________

Insurance Adjuster/Agent) ____

Phone# (_____)______________ Fax# (_____)______________

Insurance Billing Address____

City____ State_________ Zip_______________

3rd Party Insurance Company Name____

Claim #_______________________________ Policy # _____________________________

Insurance Adjuster/Agent) ____

Phone# (_____)______________ Fax# (_____)______________

Insurance Billing Address____

City____ State_________ Zip__________________

Name of Insured____

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Self-Pay Information

If you do not have health insurance, a discounted visit rate will be offered to you.

Payments must be made at the time of service to receive our discounted rates. If the payment is not received at the time of service, you will be liable for the fully charged amount.

On the visit that includes your evaluation, a discounted payment of $100.00 is offered. On each subsequent visit, a discounted rate of $75.00 will be offered.

I understand the policy stated above. I understand that I am ultimately responsible for the balance on my account for any professional services rendered.

SIGNATURE____ DATE___________________
(Parent or Guardian signature if patient is a minor)

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