Lincoln Orthopedic Physical Therapy

How did you find out about Lincoln Orthopedic Physical Therapy?
☐ Past patient/Friend or family ☐ Physician ☐ Yellow Pages ☐ Web Site
☐ Location/Street sign ☐ Attorney/Nurse Case Manager/Insurance

-- PLEASE PRINT --

Patient Information

Today's Date _____/_____/_____

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

Address_____Apartment #_____

City_____ State_____ Zip_____

Home Phone(___)_____Work Phone(___)_____Cell Phone(___)_____

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

Sex ☐ Male ☐ Female E-mail address_____

Referring Physician Name_____ Date of Injury _____/_____/_____

Employer_____ Job Title_____

Address_____

City_____ State_____ Zip_____

Primary Insurance _____Policy Holder (insured)_____

Patient relationship to insured _____Birth date of insured _____/_____/_____

Insured's Employer_____

Group number_____ ID Number_____

Secondary Insurance _____Policy Holder (insured)_____

Patient relationship to insured _____Birth date of insured _____/_____/_____

Insured's Employer _____

Group number_____ ID Number_____

Do you have Medicare? ☐ Yes ☐ No Medicare Number_____

Spouse's Name_____ Work Phone (____)_____

Emergency Contact Person _____

Relationship_____ Telephone (_____)_____

Nearest Relative/Friend Not Living With You _____

Relationship_____ Telephone (_____)_____

HIPAA PRIVACY RELEASE

The following person(s) may contact Lincoln Orthopedic Physical Therapy on my behalf to discuss my treatment and/or billing/insurance information:_____

Personal Health History

Patient Name _____ Date_____/_____/_____

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
If "Yes" 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 _____

Drug _____ Dosage _____

Lincoln Orthopedic Physical Therapy…continued

Party Responsible for Payment ☐ Same as patient information ☐ Different than patient, complete below:

Name_____

Address_____ Apartment #_____

City_____ State_____ Zip_____ Telephone (____)_____

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

Do you have an attorney representing you for the claim(s) marked above? ☐Yes ☐No

Attorney's Name_____

Attorney's Address_____ Suite #_____

City_____ State_____ Zip_____ Telephone (____)_____

Private Insurance

If you carry an insurance we do not contract with, we will submit your bill directly to them, but you are responsible for follow-up with the insurance company regarding the processing of your claim.

Patient Initials _____ Staff Initials _____

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_____/_____/___

Motor Vehicle Accident and Health Insurance Agreement

_____

Patient Name

_____/_____/_____

Date

I understand that if the motor vehicle insurance does not start making payments on my account after 30 days from this first date of service, Lincoln Orthopedic Physical Therapy will look at the possibility of billing my health insurance. I also understand that if the motor vehicle insurance pays Lincoln Orthopedic Physical Therapy any time after this 30-day period, Lincoln Orthopedic Physical Therapy will automatically reimburse my health insurance any payments they have made.

_____ _____

Staff Initials Patient Initials

Worker's Compensation Claim Information

Patient Name _____ Date____/_____/_____

What is your date of injury?____/_____/____ Initial Physical Therapy date ____/_____/____

Has a claim been filed for your job related injury? ☐Yes ☐ No

Has your claim been accepted by workers compensation? ☐ Yes ☐ No

If YES, please provide information for verification of billing information

Employer this claim is filed with _____

Human Resources contact person _____Telephone (___)_____

Claim or Case #_____

Worker's Compensation Billing Information

Insurance Adjuster _____

Telephone (____)_____ Fax (____)_____

Worker's Compensation Insurance Company_____

Address_____

Suite #_____ City _____State____Zip_____

Nurse Case Manager _____

Telephone (____)_____ Fax (____)_____

Worker's Compensation Information Calls

(Office Personnel Only)

RX Information

Referring Doctor _____ Body Part _____

Frequency _____ Duration _____

Automobile Accident/Liability Claims Information

Patient Name _____Date_____/_____/_____

Automobile Accident/Liability Claims

We will submit your bill directly to the motor vehicle/liability insurance provided we have the following information. **You** are responsible for follow-up with the insurance company regarding the processing of your claim.

Patient Initials _____ Staff Initials _____

Automobile Accident/Liability Claims

Is this auto related? ☐ Yes ☐ No Is this a liability claim? ☐ Yes ☐ No

What is the date of the motor vehicle accident or the liability injury? _____/_____/_____

Patient's Auto Insurance/Med-Pay Information

_____

Policy number _____ Claim Number_____

Insurance Contact Person (agent, adjuster, etc.) _____

Insurance Address_____ Suite #_____

City_____State____ Zip_____Telephone (_____)_____

Insurance Company Responsible for Payment/Third-Party Information

_____

Policy number _____ Claim Number_____

Insurance Contact Person (agent, adjuster, etc.) _____

Insurance Address_____ Suite #_____

City_____State____ Zip_____Telephone (_____)_____

Name of Insured _____

Attorney Information

Do you have an attorney representing you for the claim(s) listed above? ☐ Yes ☐ No

Attorney's Name_____

Attorney's Address_____ Suite #_____

City_____State____ Zip_____Telephone (_____)_____