

Lincoln Orthopedic Physical Therapy

How did you find out about Lincoln Orthopedic Physical Therapy?

- Past patient, friend or family Physician Yellow Pages Web Site Attorney
 Other *Please list...*

-- 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 (____) _____

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

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 ____ / ____ / ____

Medicare Secondary Payer Questionnaire
(Required for All Medicare patients)

Name _____ Date of Service ____/____/____

	YES	NO
1. Are you a Veteran?	<input type="checkbox"/>	<input type="checkbox"/>
a. Did the VA refer you here for treatment?	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you have a VA "fee basis" ID card?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a Federal Black Lung card?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is this medical condition due to an accident of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was it: <input type="checkbox"/> Work related <input type="checkbox"/> Auto related <input type="checkbox"/> Injury in own home		
<input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you recently received or are currently receiving home health care for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, With whom _____		
When _____		
6. Have you recently received or are currently receiving physical therapy with any other company?	<input type="checkbox"/>	<input type="checkbox"/>
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 (____) _____

Worker's Compensation Billing Information

Worker's Compensation Insurance Company _____

Address _____ Suite # _____

City _____ State _____ Zip _____ Telephone(____) _____

Insurance company's contact person _____ Fax (____) _____

Claim # _____

Worker's Compensation Information Calls

(Office Personnel Only)

Is a managed care plan involved? Yes No

(Contact person/telephone number)

RX Information _____ Referring Doctor _____

Frequency/Duration _____ Body Part _____

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? ____/____/____

What is your Auto Accident or Liability Claim #? _____

Insurance Company Responsible for Payment _____

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 (____) _____