

5590 Main Street Suite #4
 Lexington, MI 48450
 (810)359-8700 Phone
 (810)359-8702 Fax



TODAY'S DATE

/ /

PATIENT INFORMATION			
NAME(LAST)	(FIRST)	(MI)	EMAIL
ADDRESS	CITY	STATE	ZIP
TELEPHONE	DATE OF BIRTH	MARTIAL STATUS	
() -	/ /	S	D
		M	W
CELLULAR	Primary Care Physician		
() -	Referring Dr./Specialist		
EMPLOYMENT INFORMATION			
EMPLOYMENT STATUS (CIRCLE ONE)			
EMPLOYED	RETIRED	WORKING WITH RESTRICTIONS (WHAT RESTRICTIONS DO YOU CURRENTLY HAVE?) _____	
UNEMPLOYED	OFF WORK	WORKMAN'S COMPENSATION _____	
PATIENT EMPLOYER	OCCUPATION	EMPLOYER'S TELEPHONE	
		() -	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP
CONTACT INFORMATION			
SPOUSE NAME(LAST)	(FIRST)	(MI)	
ADDRESS (IF DIFFERENT FROM THE ABOVE)	CITY	STATE	ZIP
TELEPHONE	SPOUSE EMPLOYER	SPOUSE OCCUPATION	SPOUSE DATE OF BIRTH
() -			/ /
EMERGENCY CONTACT			
NAME (LAST)	(FIRST)	TELEPHONE	
		() -	
RELATIONSHIP	GUARANTOR OF ACCOUNT (NEEDED IF MINOR IS BEING TREATED)		
PLEASE LIST THE NAMES OF THOSE WE MAY CONTACT IN REGARDS TO YOUR CARE (HIPAA)			



PATIENT NAME: _____

DATE OF BIRTH: _____

ACCIDENT INFORMATION

DATE OF ACCIDENT/INJURY ____/____/____	IS THIS INJURY DUE TO WORK Y/N _____	IF SO, CLAIM NUMBER _____
	IS THIS INJURY DUE TO AN AUTO ACCIDENT Y/N _____	IF SO, CLAIM NUMBER _____

STATE ACCIDENT OCCURRED: _____

PLEASE EXPLAIN THE NATURE OF THE INJURY:

MEDICAL HISTORY

ARE YOU RECEIVING ANY TYPE OF HOME HEALTH CARE? Y/N _____

HAVE YOU RECEIVED ANY HOME HEALTH CARE IN THE LAST 30 DAYS? Y/N _____

HAVE YOU RECEIVED ANY PHYSICAL THERAPY IN THE LAST YEAR? Y/N _____ IF SO, WHEN _____ WHERE _____

HAVE YOU TAKEN CORTISONE BY PILL IN THE PAST 5 YEARS? Y/N _____

PAST HISTORY OF INJURIES/ACCIDENTS/SURGERIES (PLEASE PUT AN * NEXT TO THE HOSPITALIZATION DATES RELATED TO THE CURRENT INJURY)

DESCRIPTION:	DATE OF INCIDENT OR SURGERY:

HIGH BLOOD PRESSURE	Y/N	AUTO IMMUNE DISEASE	Y/N	LATEX ALLERGIES	Y/N
CANCER	Y/N	KIDNEY/BLADDER DISEASE	Y/N	OTHER ALLERGIES	Y/N
DIABETES	Y/N	THYROID DISEASE	Y/N	DO YOU SMOKE	Y/N
HEART DISEASE	Y/N	SKIN DISEASE	Y/N	ARE YOU PREGNANT	Y/N
LUNG DISEASE	Y/N	FIBROMYALGIA	Y/N		
STOMACH DISORDERS	Y/N	HIV POSITIVE	Y/N		
LIVER DISORDERS	Y/N	BLEEDING TENDENCIES	Y/N		
ARTHRITIS	Y/N	CIRCULATION PROBLEMS	Y/N		
RHEUMATOID ARTHRITIS	Y/N	PSYCHIATRIC DIAGNOSIS	Y/N		

TUBERCULOSIS SCREEN

IN COMPLIANCE WITH THE CURRENT OSHA REGULATIONS, WE MUST HAVE EACH PATIENT COMPLETE THE FOLLOWING QUESTIONNAIRE.

1. HAVE YOU EVER BEEN DIAGNOSED WITH TB(TUBERCULOSIS)?	Y/N
2. HAVE YOU BEEN LIVING WITH ANYONE IN THE PAST TWO YEARS WHO HAS BEEN DIAGNOSED?	Y/N
3. HAVE YOU HAD A PERSISTENT COUGH AND NIGHT SWEATS FOR MORE THAN TWO YEARS?	Y/N
4. HAVE YOU HAD A PERSISTENT COUGH AND FEVER FOR MORE THAN TWO WEEKS?	Y/N
5. HAVE YOU HAD A PERSISTENT COUGH AND LOSS OF APPETITE FOR MORE THAN TWO WEEKS?	Y/N
6. HAVE YOU BEEN COUGHING UP OF SPITTING UP BLOOD SPUTUM (SALIVA)?	Y/N

Medicare Requirement - PQRS

MEDICATIONS LIST

Are you currently taking any form of medication – including prescription, over-the-counter, herbal supplements, vitamins, minerals, or dietary supplements?

YES _____

NO _____

If you answered yes, please complete the following medication chart below. Include any medications you are currently taking which includes any or all of the following: prescriptions, over-the-counter-, herbal supplements, vitamins, or dietary supplements. Please include the name of the medication, dosage, frequency it is taken, and route (oral, injection, drops, etc.).

If you already have your medications listed somewhere else, please provide us with a copy, write "see list" below, and sign and date the bottom of this page.

Medication Name	Dosage	Frequency	Route

Patient Signature: _____ Date: _____ Date of Birth: _____



AUTHORIZATION FOR MEDICAL AND THERAPEUTIC TREATMENT

Permission is granted to the physical therapist in charge of this patient's care to administer and order services deemed necessary in the diagnosis and/or treatment of this case. I consent to having photography or videography to aid in my treatments and release Lexington Physical Therapy PLLC from any responsibility in connection with the taking of said photographs or video. No guarantees have been made to the patient regarding the results of such care and treatment which are hereby authorized.

AUTHORIZATION TO PERMIT PAYMENT OF HEALTH INSURANCE BENEFITS TO FACILITY

Lexington Physical Therapy PLLC and patient's attending physicians are authorized to release medical or other information related to outpatient, inpatient, emergency or home care to Medicare/Medicaid, Federal or Commercial Insurers for which patients may be entitled to health insurance benefits as necessary for Lexington Physical Therapy PLLC and involved physicians to receive payment for services.

The undersigned acknowledges responsibility and agrees to pay in full all remaining balances of unpaid charges due to deductibles, co-insurance or absence of insurance benefits. Lexington Physical Therapy PLLC is authorized to release any information required for an outside collection agency to collect this amount.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Lexington Physical Therapy PLLC to furnish my insurance companies and physicians any information which they may request regarding my treatment, including photocopies from my medical records, necessary to complete my claim or as required by law for this treatment and continued care.

I authorize Lexington Physical Therapy PLLC, my referring and any treating physicians to furnish information from my medical records pertaining to my medical care and continued treatment.

WAIVER OF RESPONSIBILITY FOR PERSONAL BELONGINGS

Lexington Physical Therapy PLLC is released from all responsibility for loss or damage to personal property such as money or other items retained in patient's possession.

ACKNOWLEDGEMENT OF PRIVACY POLICIES

The undersigned Patient or Legally Authorized Representative for the Patient acknowledges that he/she has been given opportunity to review and/or has received a copy of the Privacy Notice of Lexington Physical Therapy PLLC.

ACKNOWLEDGEMENT OF DISCHARGE POLICY

Please be advised that missing three (3) consecutive appointments without calling to cancel may result in discharge from Lexington Physical Therapy PLLC.

PATIENT SIGNATURE (Parent/Guardian Signature)

Date

Date of Birth

CONSENT FOR TREATMENT OF MINOR NAMED HERE: _____

I authorize Lexington Physical Therapy PLLC to treat the minor patient named above while I am not present.