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)

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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.