



Lucas Therapies, PC

Providers of Physical & Occupational Therapy

New Patient Information Form Instructions

Please fill in the Patient Information Form and bring it to your first appointment or Fax it to (540) 527-0055. Please call (540) 772-8022 to confirm receipt of your information and set up your initial therapy appointment.

Therapy Expectations:

Your first visit is known as the initial evaluation. Your therapist will interview you, asking questions about your current diagnosis and medical history. Be prepared with injury and surgery dates, if applicable. Your therapist will also examine you, and then discuss your plan of care or action appropriate to proceed with your treatment. Your care may or may not be started on the same day as the initial evaluation, however, it is always good to be prepared by wearing loose comfortable clothing. It is best to bring or wear shorts if you are being treated for a knee problem. Gowns are available but not appropriate for all situations.

Your therapist will ask how you are feeling at each visit. Please discuss with your therapist any positive or negative changes that you may be experiencing.

Please bring your insurance card and prescription for therapy with you to the appointment. These are a must even if you have pre-registered using E-mail, fax or phone.

In general, your therapy sessions will last 30 to 45 minutes. Always remember to check in at the front desk and sign your personalized encounter form. In order to be compliant with insurance guidelines, the encounter form must be signed at each visit. Be prepared to pay any co-pays or deductible amounts (see financial policies for details). Then you may be seated until your name is called. If you have not been called within 20 minutes, a friendly reminder to the front desk is appreciated.

Thank You,

Lucas Therapies, PC

LUCAS THERAPIES, PC

PATIENT INFORMATION

Name: (First) _____ (Mid Init) _____ (Last) _____
Referring Physician: _____ Primary Care Physician: _____
Date of Birth: ____/____/____ Social Security No: _____ - _____ - _____ Gender: M F
Address: _____ City: _____ Zip: _____
Telephone (Home): _____ - _____ - _____ Work: _____ - _____ - _____ Cell: _____ - _____ - _____
Employer: _____ Address _____
Email Address: _____

PARENT/SPOUSE/ RESPONSIBLE PARTY INFORMATION

Name : _____ Relationship: to patient: _____
Date Of Birth: ____/____/____ SSN# _____ - _____ - _____ Employer: _____
Address (if different): _____ City: _____ Zip: _____
Home Phone (if different): _____ - _____ - _____ Work: _____ - _____ - _____ Cell: _____ - _____ - _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____ Relationship _____

INSURANCE INFORMATION

Insurance Co: _____ Subscriber's name: _____ Date of Birth: ____/____/____ Relationship: _____

Date of Injury: ____/____/____ Is this a re-injury? Yes _____ No _____ Date of re- injury ____/____/____

Was injury (X): Where did you receive physical therapy last?

____ Work Related?
____ Motor Vehicle Accident?
____ Sports Injury? Diagnosis _____ Date of surgery ____/____/____
____ Other?

Have you received/ or are you under the services of a Home Health agency? Yes _____ No _____ If yes dates: _____
Are you currently a resident (temporarily/permanent) of a skilled nursing home? Yes _____ No _____ If yes dates: _____

For all patients:

Please call to cancel 24 hours prior to any appointment you cannot keep. If you do not show up for your scheduled appointment and do not call prior to cancel, you will be charged a \$30 No Show Fee.

I understand that any balance remaining on my account for longer than 90 days will have a late charge of 1.5% per month (18% APR) added. Should collection procedures, including any legal proceedings, be initiated to collect this debt, the undersigned agrees to pay, in addition to all sums due, attorney's fees in the amount of 33.3% and all costs incurred in the collection process. I authorize payment of insurance benefits covering these services directed to Lucas Therapies. I, also, hereby acknowledge my responsibility for full payment of this debt and waive my rights to defense under the statute of limitations.

Signature: _____ (Guardian, if under 18) Date: ____/____/____

For Medicare Patients Only:

Statement to permit payment to the provider for outpatient therapy services: I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare Claim. I request payment of authorized benefits be made on my behalf. This authorization shall apply to the period covering these services.

Signature: _____ Date: ____/____/____

Deemed Consent to HIV Testing:

In case a health care worker of this Clinic should be stuck by a needle or is directly exposed to fluids during your care which may transmit HIV virus, in accordance with Section 32.1-37.2 of the Virginia Code, you will be deemed to have consented to the Clinic's right to draw blood for testing of the HIV virus and the release of such test results to the Clinic and the worker who suffered the exposure.

Signature: _____ (Guardian, if under 18) Date: ____/____/____

Consent for care and treatment:

I, the undersigned, do hereby agree and give my consent for Lucas Therapies to furnish medical care and treatment as outlined by my physician.

Signature: _____ (Guardian, if under 18) Date: ____/____/____



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Patient History Form

Do you have a history of:

	YES	NO
Cancer		
TMJ Problems		
Jaw Clicking/Popping		
Headaches/Migraine		
Heart Disease		
High Blood Pressure		
Diabetes		
Kidney Disease		
Kidney Stones		
Gall Bladder		
Circulatory Disorders		
Night Pain		

If you answered YES to any of the above, please elaborate:

Please list all previous surgeries:

Please list any other conditions for which you have received medical treatment:

It is the patient's responsibility to disclose their full medical history. Failure to do so jeopardizes the therapist's ability to provide adequate care. Your signature below denotes that you have disclosed all of your medical history.

Name: _____ Date: _____



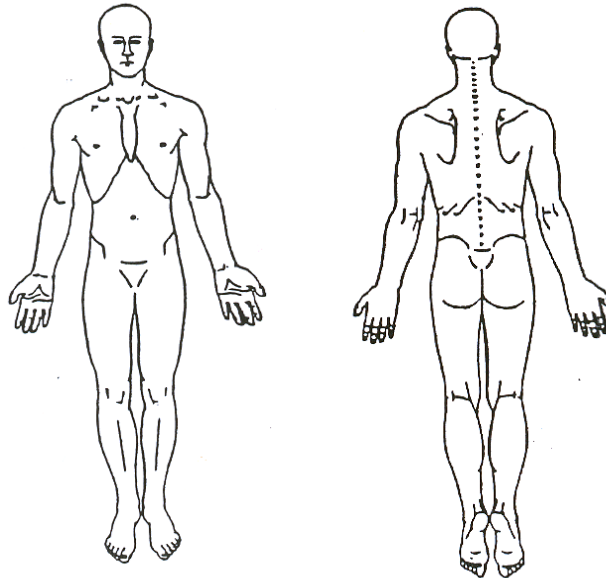
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In the following groups of words, please circle any word that describes the pain you are experiencing right now. You do not have to choose a word from every group.

1. Flickering, Quivering, Pulsing, Throbbing, Beating, Pounding
2. Jumping, Flashing, Shooting
3. Pricking, Boring, Drilling, Stabbing, Lancinating
4. Sharp, Cutting, Lacerating
5. Pinching, Pressing, Gnawing, Cramping, Crushing
6. Tugging, Pulling, Wrenching
7. Hot, Burning, Scalding, Searing
8. Tingling, Itchy, Smarting, Stinging
9. Dull, Sore, Hurting, Aching, Heavy
10. Tender, Taut, Rasping, Splitting
11. Tiring, Exhausting
12. Sickening, Suffocating
13. Fearful, Frightful, Terrifying
14. Punishing, Grueling, Cruel, Vicious, Killing
15. Wretched, Blinding
16. Annoying, Troublesome, Miserable, Intense, Unbearable
17. Spreading, Radiating, Penetrating, Piercing
18. Tight, Numb, Drawing, Squeezing, Tearing
19. Cool, Cold, Freezing
20. Nagging, Nauseating, Agonizing, Dreadful, Torturing

On the drawing below, please darken the area where your pain is located.



Please mark an (X) across the line to indicate how bad your pain is today.

No Pain at all [_____] Pain as bad as it could be



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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I may request a copy of Privacy Practices from Lucas Therapies, PC.

X _____ Date: _____

In lieu of patient signature, I _____, a staff member of Lucas Therapies, PC, state that _____ has been given our current Notice of Privacy Practices.

X _____ Date: _____