5640 S 84th Street, Suite 100
Lincoln, NE 68516
Phone: 402-486-0602

New Patient Information Form

Patient Information

Name: ____ Date of Birth: ________________ Age: ________________
Nickname: __________________________________ Email address (optional): __________________________________
Address: ____ City: _____________ State: _____________ Zip: __________
Home Phone: ____________________________ Cell Phone: ________________________ Work Phone: _____________
SS#: ______________________________ Gender: M or F Marital Status: Single Married Widowed Divorced
Employer: _________________________________ Occupation: ____
Who referred you to our office? ____
Reason for visit: ____ Onset of current condition: ___________________
Do you reside in a long term care or skilled nursing facility? Y or N

Insurance Information

Primary Insurance Company: ____
Primary Insured Name: __________________________________ Primary Insured Date of Birth: ____________________
Relationship to patient: __________________________________
Primary Insurance ID #: ___________________________________ Primary Insurance Group #: _____________________

Secondary Insurance Company: ____
Primary Insured Name: __________________________________ Primary Insured Date of Birth: ____________________
Relationship to patient: __________________________________
Secondary Insurance ID #: ________________________________ Secondary Insurance Group #: ____________________

If someone other than the patient being seen is responsible, please list responsible party below:
Responsible Party Name: ____________________________________ Responsible Party Date of Birth: _______________
Relationship to patient: __________________________________
Address: ____ City: _____________ State: _____________ Zip: __________

In case of Emergency:

Who would you like us to contact in case of an emergency?
Name: ________________________________ Phone Number: ______________ Relationship to patent: ______________

Worker's Compensation or Auto Accident Information:

Were you injured at your job? If so, please complete the following information.
Employer name: __________________________ Contact Person: ___________________ Phone Number: _____________
How were you injured: ____ Date of injury: __________________________
Worker's Comp insurance company name: _____________________________ Claim #: ___________________________
Were you involved in an auto accident? If so, please complete the following information.
Auto Insurance Company: ____
Contact Person: _____________________________________ Phone Number: ____________________________________
Claim #: ____________________________________ Date of accident: ____
Are you currently working with an attorney? If so, please list below:
Name of Attorney: ____ Phone Number: _______________________________

Consent for Treatment/Assignment of Benefits/ Release of Information

I certify that the information provided above is true and correct to the best of my knowledge and belief. I authorize this clinic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners.

I authorize Advanced Physical Therapy to provide rehabilitation services to me and/or develop, modify, and progress at the direction of Advanced Physical Therapy clinicians and/or my physician. I authorize and request my insurance company to pay directly to the physical therapist's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances.

Medicare patients only: Certification and Financial Agreement – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Health Care Financing Administration (Medicare) and its agents any information needed for this or a related Medicare claim. I request that the payment for authorized benefits be made directly to Advanced Physical Therapy on my behalf. I understand that I am responsible for any medical insurance deductible and co-insurance, and for the cost of the difference of any private accommodation in which I am placed at my own request.

A wide variety of means for communication exists and continues to broaden and develop. By signing this Authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. Specifically, if I provide a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers. For any landline and cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and our service providers may use recorded messages. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

We utilize a third party billing service, Practice Max, and any communication or correspondence is permitted by Practice Max for correct billing and payment.

Patient Name: ____ Date: ________________________________

Patient Signature: _____________________________________