LUCAS THERAPIES, PC

PATIENT INFORMATION		
Last name:	First name:	Middle initial:
Date of Birth:	Social Sec. #:	Gender: Male Female
Address:		Home Phone:
City, State, Zip:		Work Phone:
Email address:		Cell Phone:
Referring Physician:		Primary Care Physician:
RESPONSIBLE PARTY INFORMATION		
Relationship to Patient:		
Last name:	First name:	Middle initial:
Address (if different):		Date of Birth:
City, State, Zip:		Social Security #:
		Phone number:
EMERGENCY CONTACT		
Name:	Phone Number:	Relationship:
INSURANCE INFORMATION		
Primary Insurance Company:		Subscribers DOB:
Subscribers name:		Subscribers SSN#.
Policy ID:		Relationship to subscriber:
Group number:		
Secondary Insurance Company:		Subscribers DOB:
Subscribers name:		Subscribers SSN#.
Policy ID:		Relationship to subscriber:
Group number:		
VISIT INFORMATION		
Date of injury:	Date of surgery:	Employer:
How did your injury occur:	Work injury? Yes No	Claim #:
	Motor Vehicle accident? Yes No	
	Sports injury? Yes No	
Have you received or are you currently receiving Home Health? Yes No		

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 $45.00 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 30% 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. You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address or phone number you provide to us. Please notify us if you do not wish to receive text/email appointment reminders. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device as applicable. I have read this disclosure and agree that Lucas Physical Therapy or any of their Collection Agencies may contact me as described above. **ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES:** I acknowledge that I may request a copy of Privacy Practices from Lucas Therapies, PC. **CONSENT FOR CARE AND TREATMENT** I, the undersigned, do herby 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: ____/_____/____

Your signature denotes that you are aware of, and are in agreeance of all policies listed above.

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: ____/_____/_____

LUCAS THERAPIES, PC

PATIENT HEALTH HISTORY					
Do you have a history of?	**Yes**	**No**		**Yes**	**No**
Cancer			Fracture		
Diabetes			Seizures		
High blood pressure			Bowel/Bladder disorder		
Heart problems			Dizziness		
Headaches/Migraine			Numbness/Tingling		
Arthritis			Emotional/psychological		
Stroke/CVA			Pregnancies		
Blood clots/vascular			Do you use tobacco?		
Please list any other conditions for which you have received medical treatment?					
Please list medications you are currently taking:					
Please list all previous surgeries?					

PAIN/SYMPTOMS

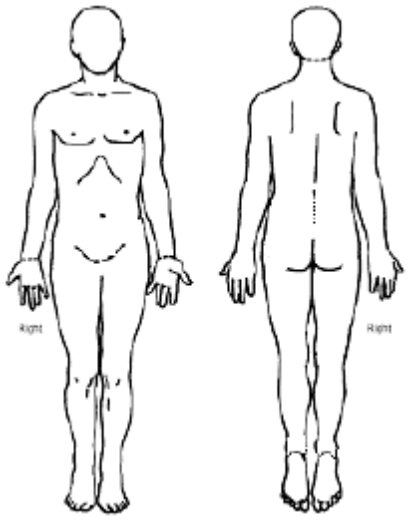
Please mark you pain on the scale below from 0 to 10.

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

0 1 2 3 4 5 6 7 8 9 10

On the Body Diagram to the right, mark the areas of your pain and describe your symptoms using the following symbols:

(X)Sharp (+)Numb/Tingling (#)Ache
(B)Burning



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 you have disclosed all of your medical history.

Name:_____ Date:_____