

RIVER CITY REHABILITATION, LLC

1707 South Colorado, Suite A – GREENVILLE, MS 38703

Thank you for choosing our office. In order to serve you properly we will need the following information. All information will be strictly confidential. PLEASE PRINT.

Patient Information

Patient's name _____] Male ___ Female ___] Marital status S M W D SEP Age _____

Date of birth _____] Social security # _____]

HAVE YOU EVER RECEIVED TREATMENT FROM RIVER CITY REHAB? () YES () NO
IF YES, WHEN? _____

Patient's address _____

City and state _____] Zip code _____] Home phone # _____

Cell or other number _____

Patient's Employer _____ Work telephone number _____

Employer's address _____

Spouse's name _____] Age _____] Date of birth _____] social security # _____

Name and address of someone to notify (in case of emergency, other than spouse) _____

Relationship _____ Phone number _____

***Have you received HOME HEALTH SERVICES IN THE LAST MONTH?** ___ YES ___ NO

EMAIL ADDRESS: _____

Insurance Information

Was this injury due to an auto accident? _____ Date of accident _____

Are you represented by an attorney? ___ yes ___ no Name of attorney _____

Primary Insurance Co. _____ Secondary Insurance Co. _____

Address _____ Address _____

Group # _____ ID # _____ Group# _____ ID# _____

Name of insured _____ Name of insured _____

Date of birth _____ SS# _____ Date of birth _____ SS# _____

Worker's Compensation

Insurance Carrier _____] Date of accident _____] Claim # _____

Complete address _____] Adjuster's name _____] Tele # _____

Referring Physician Name _____] Next doctor's appointment date and time _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What are your current symptoms or injury? _____
Date of onset symptoms or injury? _____

Have you had surgery for current injury or symptoms? Y N
If yes, date of surgery: _____

Do you have a pacemaker/other implants? Y N

Rate your pain on a scale from 1 to 10 (10 being the worse): 1 2 3 4 5 6 7 8 9 10

What makes your pain worse?

- Coughing
- Sitting
- Standing
- Walking
- Lying
- Bending forward
- Twisting
- Moving from sitting to standing
- Lifting
- Driving

Indicate with an "x" which of the symptoms below you presently suffer from

- Seizures/stroke
- Cancer
- Diabetes Type : __1__ __2__
- Bleeding problems
- Blood clots
- Anemia
- HIV
- Depression
- Chest pain/angina
- Heart attack/disease
- Dizziness
- Arthritis
- Shortness of breath
- Nausea/vomiting
- Numbness/tingling If yes, where? _____
- Blood pressure
- Asthma
- Seizures
- Fainting
- Trouble Sleeping

DUE TO HEALTH CARE REGULATIONS, PLEASE COMPLETE THE NEXT PAGE (MEDICATION INFORMATION) .

PATIENT INFORMATION

Welcome to River City Rehabilitation, LLC. It is to our mutual benefit that our patients understand our Payment Policy. We make every effort to keep the cost of your medical care to a minimum. If your insurance company is one with which we participate, we will bill your insurance company as agreed between River City Rehabilitation, LLC., and the respective insurance company. Ultimately, responsibility for payment lies with the patient. Payment not received from the insurance company, deductible, co-payment, co-insurance, and any remaining balance after insurance will be the responsibility of the patient. _____ (Initial)

PAYMENT POLICY

I, the undersigned, hereby authorize River City Rehabilitation, LLC. to apply for benefits on my behalf for covered services rendered to me, not paid in full today. _____ (Initial)

I request payment from my Medicare/ insurance carrier, if any be made directly to River City Rehabilitation, LLC. _____ (Initial)

I certify that the information reported with regard to insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim, to the insurance carrier. In making this assignment, I understand and agree that I am financially responsible for charges not paid under this insurance policy. _____ (Initial)

RELEASE INFORMATION

River City Rehabilitation, LLC. may disclose any or part of this medical record to my insurance company (or companies), attorneys, or employer, for workmen’s compensation, spouses _____ (Initial)

RELEASE

In consideration of my use of River City Rehabilitation, LLC., services, I hereby release and discharge River City Rehabilitation, it’s owners, affiliates, agents, employees, successors, and assigns, of and from any liabilities, suits, claims, and demands for damages or losses incurred by me or in any way related to or arising out of my use of these premises. _____ (Initial)

AUTHORIZATION

I authorize River City Rehabilitation, LLC., to perform treatment to me/my child in accordance to my physician’s orders. I understand that I can refuse treatment and that an explanation of possible consequences resulting in the refusal of treatment will be provided for me, and my physician will be notified. Also, I acknowledge that I have received a copy of the Patient’s Bill of Rights by this facility and understand my rights. _____ (Initial)

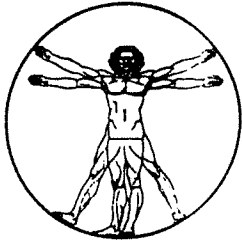
GUARANTEE OF PAYMENT

To River City Rehabilitation, LLC: I guarantee payment of all said charges incurred in accordance with the policy of payment of bills. In the event the account must be placed with an attorney or collection agency to obtain payment, I shall be responsible for all attorney and collection agency fees incurred. _____ (Initial)

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS

_____ **RESPONSIBLE PARTY SIGNATURE**

_____ **DATE**



River City Rehabilitation, LLC

Michelle Fiser, PT
Stephen Jernigan, PT
Lesli Porter, OT

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____

Social Security #: _____ **Date of Birth:** _____

**Release my protected health information to the following
physician/person/facility/entity.**

Name: _____

Address: _____

Telephone#: _____ **Contact Person:** _____

I understand that River City Rehabilitation, LLC, will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information will be charged according to rulings set forth by the State of Mississippi.

Patient Signature: _____

Printed Patient Signature: _____

Patient Guardian: _____

Printed Patient Guardian: _____

Date: _____

Medicare Secondary Payer (MSP) Questionnaire

Patient Name _____ Date: _____

HICN: _____

Part I

1. Are you receiving Black Lung (BL) Benefits?

Yes Date benefits began: _____ (MM/DD/CCYY)

BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.

No

2. Are the services to be paid by a government research program?

Yes

Government Research Program will pay primary benefits for these services

No

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

Yes

DVA IS PRIMARY FOR THESE SERVICES.

No

4. Was the illness/injury due to a work related accident/condition?

Yes Date of injury/illness: _____ (MM/DD/CCYY)

Name and address of worker's compensation (WC) plan:

Policy or identification number: _____

Name and address of your employer:

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.

No **GO TO PART II.**

Part II

1. Was illness/injury due to a non-work related accident?

Yes Date of accident: _____ (MM/DD/CCYY)

No **GO TO PART III**

Medicare Secondary Payer (MSP) Questionnaire (page 2)

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)

Yes

Name and address of no-fault insurer(s) and no-fault insurance policy owner:

Insurance claim number(s): _____

No

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)

Yes

Name and address of any liability insurer(s) and responsible party:

Insurance claim number: _____

No

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABILITY SETTLEMENT, JUDGEMENT, OR AWARD. GO TO PART III.

No **GO TO PART III**

Part III

1. Are you entitled to Medicare based on:

Age **Go to Part IV.**

Disability **Go to Part V.**

End Stage Renal Disease (ESRD) **Go to Part VI.**

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections.

Part IV – Age

1. Are you currently employed?

Yes

Medicare Secondary Payer (MSP) Questionnaire (page 3)

Name and address of your employer:

No If applicable, date of retirement: _____ (MM/DD/CCYY)

No Never employed

2. Do you have a spouse who is currently employed?

Yes

Name and address of spouse's employer:

No If applicable, date of retirement: _____ (MM/DD/CCYY)

No Never Employed

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

Yes, Both

Yes, Self

Yes, Spouse

No **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?

Yes **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): _____

Medicare Secondary Payer (MSP) Questionnaire (page 4)

Name of policyholder/named insured: _____

Relationship to patient: _____

No

5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?

Yes **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

No

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 4 AND 5, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART 1 OR 11.

Part V - Disability

1. Are you currently employed?

Yes

Name and address of your employer:

No If applicable, date of retirement: _____ (MM/DD/CCYY)

No Never Employed

2. Do you have a spouse who is currently employed?

Yes

Name and address of your spouse's employer:

Medicare Secondary Payer (MSP) Questionnaire (page 5)

No If applicable, date of retirement: _____ (MM/DD/CCYY)

No Never Employed

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?

Yes, Both

Yes, Self

Yes, Spouse

No

4. Are you covered under the group health plan of a family member other than your spouse?

Yes

Name and address of your family member's employer:

No

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 1, 2, 3, AND 4, STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART 1 OR II.

5. If you have GHP coverage based on your own current employment, does your employer, that sponsors or contributes to the GHP, employ 100 or more employees?

Yes **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

No

6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 100 or more employees?

Yes **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Medicare Secondary Payer (MSP) Questionnaire (page 6)

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

No

7. If you have GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?

Yes **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

No

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 5, 6, AND 7, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

Part VI – ESRD

1. Do you have group health plan (GHP) coverage?

Yes

IF APPLICABLE, YOUR GHP INFORMATION:

Name and address of GHP:

Medicare Secondary Payer (MSP) Questionnaire (page 7)

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

IF APPLICABLE, YOUR SPOUSE'S GHP INFORMATION:

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which your spouse receives GHP coverage:

IF APPLICABLE, YOUR FAMILY MEMBER'S GHP INFORMATION:

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Medicare Secondary Payer (MSP) Questionnaire (page 8)

Relationship to patient: _____

Name and address of employer, if any, from which your family member receives GHP coverage:

No **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

Yes Date of transplant: _____ (MM/DD/CCYY)

No

3. Have you received maintenance dialysis treatments?

Yes Date dialysis began: _____ (MM/DD/CCYY)

If you participated in a self-dialysis training program, provide date training started:

_____ (MM/DD/CCYY)

No

4. Are you within the 30-month coordination period that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

Yes

No **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

Yes

No

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

Yes **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

No **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement)?

Yes **GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

No **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the types of questions above and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.