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 ADDDRESS:____

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).

RIVER CITY REHABILITATION AND SPORTS MEDICINE

Medication Name	Dosage	Frequency	Route (How taken)

I certify that this is a complete list of all medications that I take including prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements. I also agree to let the therapist know if there is ever a change.

Signature:______________________________ Date:______________

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)

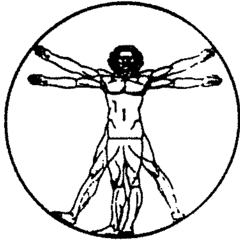
I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS

____

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:______________________

1707 South Colorado Street Suite A • Greenville, MS 38703 • Phone (662) 335-8332 • Fax (662) 335-8852

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.