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

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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)

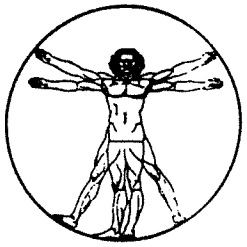
I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS

_____

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:_____

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