TMC REHAB

Please complete the following pages in BLACK INK only

EVAL DATE:

PATIENT INFORMATION

LAST NAME	FIRST	MI
ADDRESS (STREET, CITY, STATE ZIP)		
ADDRESS CON'T	SSN	DOB
HOME PHONE	WORK PHONE EXT.	CELL PHONE

IS INJURY RELATED TO: ☐ WORK ☐ AUTO ☐ OTHER IF WORK, COMPLETE WORK RELATED INJURY INFORMATION BELOW.
IS A HOME HEALTH AGENCY CURRENTLY PROVIDING NURSING SERVICES IN YOUR HOME? ☐ YES ☐ NO
HAVE YOU HAD ANY THERAPY SERVICES IN THE LAST 12 MONTHS? ☐ YES ☐ NO

EMERGENCY CONTACT NAME	**RELATIONSHIP**	**PHONE NUMBER**

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME (PARENT/GUARDIAN/OTHER, WHO BROUGHT MINOR FOR THERAPY)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SSN
ADDRESS (STREET, CITY, STATE ZIP)		
HOME PHONE	WORK PHONE EXT.	CELL PHONE

WORK RELATED INJURY

EMPLOYER NAME:	CASE MANAGER NAME:	CASE MANAGER PHONE:
EMPLOYER ADDRESS (STREET, CITY, STATE ZIP)		CASE MANAGER FAX:
EMPLOYER LIABILITY CARRIER	LIABILITY CARRIER ADDRESS	
DATE OF INJURY	CLAIM #:	NUMBER OF VISITS APPROVED:

TO BE COMPLETED BY OFFICE

IS THE PATIENT THE SUBSCRIBER? ☐ YES ☐ NO	IF NO, THEN: SUBSCRIBER/ POLICYHOLDER NAME:	DOB
SUBSCRIBER/POLICYHOLDER ADDRESS (IF OTHER THAN PATIENT):		

PRIMARY INSURANCE	**ID #**	**GROUP #**

INSURANCE EFFECTIVE DATE:		PRE-CERT REQUIRED: ☐ YES ☐ NO
PERSON QUOTING BENEFITS:		PRE-CERT CONTACT:
DEDUCTIBLE AMOUNT:	DEDUCTIBLE AMOUNT MET:	PRE-CERT INFORMATION:
COPAY $:	COINSURANCE %:	
OUT OF POCKET AMOUNT:	OUT OF POCKET AMOUNT MET:	DOES PRE-EXISTING APPLY? ☐ YES ☐ NO
LIMITATIONS/EXCLUSIONS:		
CLAIMS MAILING ADDRESS:		PHONE:

INITIALS	I confirm that my quote of benefits has been provided to me and I have been given the opportunity to address any questions with the front office staff regarding this quote.

INFORMED CONSENT

I consent to treatment rendered by TMC Rehab/Winder HMA, LLC as ordered or approved by my physician. I agree to participate in TMC Rehab/Winder HMA, LLC's program to the best of my ability to facilitate a rapid and full recovery.

I consent to having my picture taken for objective analysis of my condition. This information will be used solely for the purpose of education of myself for my condition and to compare pre and post treatment outcomes. Any other use of this information will require my written consent.

I understand that some increase in pain may be normal. I must determine how much pain increase is acceptable to me, and I may be asked to describe any pain using a Visual Analog Scale. I will not be asked to perform activities that increase my pain to a level that is unsafe or undesirable to me. I will be asked to perform activities, but will not be forced to perform any activity that I believe unsafe. I will be informed if I'm seen doing anything unsafe or that jeopardizes my recovery.

CONSENT FOR RELEASE OF INFORMATION

Insurers may release to TMC Rehab/Winder HMA, LLC any information regarding the extent of my insurance coverage, information concerning the status of claims submitted by TMC Rehab/Winder HMA, LLC and information regarding payments made directly to me on those claims. TMC Rehab/Winder HMA, LLC may obtain any information and/or medical records pertinent to "treatment" provided from hospitals, physicians, nursing agencies, and other health care providers, Pursuant to the privacy rule 45CFR164.501 of HIPAA, "treatment" generally means the provision, coordination, or management of health care and related services among providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

AUTHORIZATION FOR DISCLOSURE

I, a patient of TMC Rehab/Winder HMA, LLC, give my expressed permission to discuss with the individual(s) I have listed:

Please check appropriate box(es): ☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name: _____Relationship:_____Phone:(____)_____
Name: _____Relationship:_____Phone:(____)_____
Name: _____Relationship:_____Phone:(____)_____

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

A confidential message (i.e.: appointment reminders) may be left on your telephone answering machine or voicemail.
If you would like to receive these calls at an alternate number, please list: (_____)_____

ASSIGNMENT OF BENEFITS

I understand that I am ultimately responsible for the charges incurred for my services by TMC Rehab/Winder HMA, LLC, whether the Benefits are through Commercial Insurance, Workers' Compensation or a Third-Party Payor (i.e.: auto accident).

I also understand that additional information may be required of me to assist TMC Rehab/Winder HMA, LLC in filing such claims. I may have to provide information from the following list regardless of my insurance:

- Social Security Number
- Date of Birth
- Copy of Insurance Card (for commercial filing and/or workers' compensation)
- Name of employer, Employer address, phone number and contact person
- Auto Insurance

TMC Rehab/Winder HMA, LLC will file my insurance claims as a courtesy, and I understand that any quoted benefits given at the time of service are not a guarantee of payment. I assign all benefits paid by insurance to be paid directly to TMC Rehab/Winder HMA, LLC. By my signature below I acknowledge my responsibility and assign said benefits and verify that I have read and agree to the terms of TMC Rehab/Winder HMA, LLC Payment Policy.

I have read and understand the above and foregoing Informed Consent, Consent for Release of Information, Authorization for Disclosure and Assignment of Benefits, and agree with the terms thereof.

_____	_____	_____	_____
PATIENT NAME	**SIGNATURE OF PATIENT/GUARDIAN**	**DATE**	**WITNESS**

MEDICAL HISTORY QUESTIONNAIRE (*PLEASE PRINT*)		**DATE**
PATIENT LAST NAME	FIRST	MI
DATE OF ONSET OF INJURY/CONDITION:	FAMILY PHYSICIAN	REFERRING PHYSICIAN
HAVE YOU EVER HAD SURGERY FOR THIS INJURY? □ *YES* □ *NO*	*IF YES, TYPE OF SURGERY:*	*DATE OF SURGERY:*
HAVE YOU HAD PREVIOUS PHYSICAL THERAPY FOR THIS CONDITION? □ *YES* □ *NO*		
DO YOU SMOKE? □ *YES* □ *NO*	*ARE YOU PREGNANT OR THINK YOU MIGHT BE PREGNANT?* □ *YES* □ *NO*	
HOW HAS YOUR INJURY AFFECTED YOU EMOTIONALLY? □ *DEPRESSION* □ *WITHDRAWAL* □ *ANGER* □ *ANXIETY* □ *NONE* □ *OTHER, PLEASE LIST:*		
WHAT IS THE SEVERITY OF YOUR EMOTIONAL REACTION? SCALE OF 1(LOW) - 10(HIGH)	*WHO IS YOUR FAMILY/COMMUNITY SUPPORT?*	
LIST **ALL** MEDICATION (S) YOU ARE ALLERGIC TO:		
DO YOU HAVE ANY SENSITIVITY TO LATEX THAT YOU ARE AWARE OF? □ YES □ NO		
LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING, EITHER PRESCRIPTION OR NON-PRESCRIPTION:		
PLEASE LIST ANY OTHER HEALTH CARE PROFESSIONALS WHOSE CARE YOU ARE CURRENTLY UNDER FOR THIS CONDITION:		
IS THERE ANY OTHER INFORMATION THAT WOULD ASSIST US WITH YOUR CARE?		

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

YES	NO		YES	NO	
☐	☐	Cancer	☐	☐	Infectious Diseases
☐	☐	Chest Pain or Shortness of Breath	☐	☐	Hepatitis
☐	☐	Heart Diseases	☐	☐	Headaches Frequent/Severe
☐	☐	High Blood Pressure	☐	☐	Hearing/Vision Difficulties
☐	☐	Pacemaker	☐	☐	Numbness or Tingling
☐	☐	Heart Attack	☐	☐	Dizziness
☐	☐	Stroke or TIA	☐	☐	Weakness
☐	☐	Congestive Heart Disease			
☐	☐	Blood Clots			**Surgery or Injury of any of the following:**
☐	☐	Circulation Problems	☐	☐	Neck-Type:_____
☐	☐	Seizure Disorder or Epilepsy	☐	☐	Back-Type:_____
☐	☐	Thyroid Problems	☐	☐	Shoulder-Type:_____
☐	☐	Asthma, Emphysema or Bronchitis	☐	☐	Elbow-type:_____
☐	☐	Chemical Dependency	☐	☐	Hand-Type:_____
☐	☐	Diabetes	☐	☐	Hip-Type:_____
☐	☐	Rheumatoid Arthritis	☐	☐	Knee-Type:_____
☐	☐	Other Arthritis Conditions	☐	☐	Ankle or Foot-Type:_____
☐	☐	Fibromyalgia			

FALLS ASSESSMENT NEEDS	**YES**	**NO**
Have you fallen in the past six (6) months?	❑	❑
Do you take ANY of the following prescription medications: narcotics, high blood pressure medication, diuretics (water pills), heart medication?	❑	❑
Do you feel dizzy when you get up from a chair or bed?	❑	❑
Do you have uncorrected vision problems with reading or driving?	❑	❑
Are you over 65 years of age?	❑	❑

**If you answered "yes" to 2 or more questions, you could be at risk for a fall (Therapist-further assessment may be indicated).*

TMC Rehab, A BRMC Therapy and Wellness Provider
Medicare Secondary Payer Questionnaire

PATIENT NAME	MEDICARE NO:
ONSET DATE:	DATE OF SERVICE:
INFORMATION SUPPLIED BY:	RELATIONSHIP:

1. Is this illness/injury covered under the Federal Black Lung Program? ☐ Yes ☐ No
(If yes, Federal BL Program is primary for claims related to BL) Date benefits began:

2. Is treatment for this illness/injury authorized by the Veteran's Administration? ☐ Yes ☐ No
(If yes, DVA is primary)

3. Is this illness or injury due to a work-related accident/condition? ☐ Yes ☐ No

Employer Name & Address:

(If yes, worker's compensation insurer is primary. Collect appropriate insurance information)

4. Is this illness/injury covered under no-fault or automobile insurance? ☐ Yes ☐ No
(If yes, no-fault/auto ins is primary. Collect appropriate insurance information)

5. Is this an illness or injury for which another party could be held liable? ☐ Yes ☐ No
(If yes, liability ins is primary. Collect appropriate insurance information)

6. Is patient insured by an employer group health plan due to current employment of self? ☐ Yes ☐ No
Date coverage began: _____
If yes, how many employees work for the sponsoring employer? ☐ Don't know ☐ 1-19 ☐20-99 ☐ 100 or more
(If yes, EGHP is primary. Collect appropriate insurance information)

7. Is patient insured by an employer group health plan due to current employment of spouse or other family member? ☐ Yes ☐ No
Date coverage began: _____
If yes, how many employees work for the sponsoring employer? ☐ Don't know ☐ 1-19 ☐20-99 ☐ 100 or more
(If yes, EGHP is primary. Collect appropriate insurance information)

8. Is patient under 65 and entitled to Medicare due to disability? ☐ Yes ☐ No
Is patient insured by an employer group health plan? ☐ Yes ☐ No
(If yes to **both** questions, EGHP is primary. Collect appropriate insurance information)

9. Is patient entitled to Medicare due to End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
Is patient insured by an employer group health plan? ☐ Yes ☐ No
Is patient within the 30-month coordination period? ☐ Yes ☐ No
(If yes to **all** question, EGHP is primary. Collect appropriate insurance information)

10. If applicable, attorney's name and address:

If all questions are answered **NO**, Medicare is the primary payer

11. Are you a member of a Medicare health maintenance organization (HMO) program? ☐ Yes ☐ No

12. Have you been hospitalized in the past 60 days? ☐ Yes ☐ No

If yes, when and where?