PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

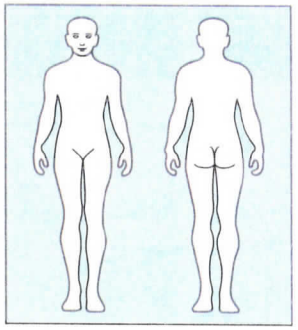
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____
Pharmacy Name _____
Pharmacy Phone (_____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

ACKNOWLWDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Rehab World/ Rolando Gersava P.T. Reserves the right to modify the primary practices as deemed appropriate

Please sign the Following:

Name of Patient: _____

Signature of Patient: _____

Today's Date: _____

If Patient is a minor, Representative sign here: _____

What is the Relationship of Representative to the Minor Patient? _____

Thank You
Management

Rehab World, Inc.
7070 HWY 64
Oakland, Tn. 38060
Phone : (901) 465-9191
Fax: (901) 465-9323

SERVICE AGREEMENT

Patient's Name: _____ Health Insurance: _____
Policy / Group #: _____

PATIENT CERTIFCATION:
AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

1. **Consent for Treatment:**

   I _____ (client) and _____ (Responsible Patient hereby authorize the subsidiaries of Rehab World (hereunder referred to as Rehab World) to administer and perform therapy services which have been prescribed by my physician and under the risk and benefits of such services (if services require a physician prescription by applicable state / federal laws).

2. **Responsible Party:**

   The responsible party shall be defined as an individual, individuals or organization that shall guarantee the performance of the client's responsibilities with regard to all terms and condition of this agreement.

3. **Medicare / Other insurance Patients:**

   I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request payment of authorized benefits is made on my behalf. I herby authorize Rehab World, Inc. to act as agent of the client in regards to consideration of appeals of denied claims with Medicare and other insurance companies.

4. **Clients and / or Responsible Party bill of rights and responsibility**:

   The client and or responsible party hereby certifies that payment will be made to Rehab World, Inc., all accounts that are not covered by insurance (s), deductibles and co-payments in which clients are responsible party will be responsible for payment when services are rendered or prior arrangements are made. The client (s) or responsible party agrees to pay attorney's fees and cost of collection, of any past due patient balance if this account is referred to an outside agency for collection or the attorney.

5. **Agreed and Understood:**

   Both the Client and or Responsible Party have agreed to the terms and conditions of this service agreement and understood the implications of such.

   Client's Signature: _____ Date: _____
   Responsible Party Signature: _____ Date: _____

Patient Screening Tool

Infection Control and Prevention Concerning COVID-19

In accordance with CMS' Home Health Guidance and Actions related to taking appropriate action to address potential and confirmed COVID cases and mitigate transmission including screening, treatment, and transfer to higher level care (when appropriate).

Assess every patient on every visit by any discipline,

before or immediately upon arrival to the home.

Upload this tool with the associated visit note.

	No	Yes
1. **Within the last 14 days, have you had international travel to countries with sustained community transmission?** *https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html*		
2. **Do you have signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat?@**		**specify in visit note**
3. **In the last 14 days, have you had contact with someone who has been diagnosed with COVID-19, is under investigation for COVID-19, or who is ill with a respiratory illness?**		
4. **Do you reside in a community where community-based spread of COVID-19 is occurring?**		

@ **FOR ILL PATIENTS**

- **Implement source control measures** (i.e., placing a facemask over the patient's nose and mouth)
- **Notify the Clinical Manager** who will notify the local/state authorities of a person under investigation (PUI) for COVID-19.
- **Notify the patient's physician** of the symptoms and determine plan (for example, need for increased visits to observe and assess, in-home management, transfer to a facility…)
- **Assess the potential for safe in-home management of mild symptoms** including the ability and willingness to self-isolate and to self-monitor and report changes, potential risk of secondary transmission to immunocompromised household members…
- **Provide patient / caregiver education** regarding infection control for respiratory illnesses (self-isolation, monitoring and reporting, hand- hygiene, cleaning high-touch surfaces daily, avoid sharing personal items, restriction to 1 room in the home with the door closed, limit visitors / contacts, respiratory hygiene, have the patient wear a mask when outside the room and in the presence of others… (refer to the Pt Orientation Booklet)

SUPPLIES: CMS regulations requires that home health agencies provide the types of services, supplies and equipment required by the individualized plan of care. HHA's are normally expected to provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS). *State and Federal surveyors will not cite home health agencies for not providing certain supplies (e.g., personal protective equipment (PPE) such as gowns, respirators, surgical masks and alcohol-based hand rubs (ABHR)) if they are having difficulty obtaining these supplies for reasons outside of their control.* However, providers must take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible.

IF THE PATIENT HAS OR DEVELOPS MORE SEVERE SYMPTOMS AND REQUIRES TRANSFER TO A HOSPITAL: PRIOR TO TRANSFER, alert emergency medical services and the receiving hospital to the patient's diagnosis and precautions to be taken including placing a facemask on the patient during transfer.

Clinician signature and Title: _____ **Date:** _____ **Time:** _____

Pt Name: _____ **MR#:** _____