direct REHABMED

Better Care For Better Living

Thank you for choosing Direct RehabMed for your healthcare needs.

The following pages include our new patient registration paperwork that is required for your visit. We would appreciate it if you would complete this paperwork, in its entirety, and bring it with you to your appointment. **Please arrive 30 minutes before your appointment** so enough time is allowed to process your paperwork and copy your insurance card(s) and photo ID.

If you do not have your required paperwork completed by your scheduled appointment time, you may be asked to reschedule your appointment.

It is very important that you bring your driver's license or photo ID, a list of your current medications, your insurance cards and/or any medical records and/or diagnostic testing reports, e.g. MRI, CT, X-Rays (if required by your physician).

It will also be your responsibility, and the policy of Direct RehabMed, that you notify our office **twenty-four (24) hours** in advance if you will not be able to keep your appointment. As stated in our Financial Policy, a fee of $50.00 may be charged to you when twenty-four (24) hour notice is not given.

We welcome you to Direct RehabMed and look forward to serving you.

Sincerely,

The Physicians, Providers and Staff of Direct RehabMed

As used above, the term Direct RehabMed shall mean Ritesh R. Prasad, M.D., East Texas Spine Institute, P.A., C Perry Marshall, M.D., DRM Business Health, PLLC, Direct RehabMed, Coby Marrow, P.T., William Farrar, LPC, and/or Racheal Cox, CCC-SLP.

GROUP INSURANCE/MEDICARE PATIENT INFORMATION

ABOUT YOU - Please give your driver's license and insurance card(s) to front desk for scanning

Last Name: _____ First Name: _____ MI: _____
Address: _____ City, State, Zip: _____
Home #: (_____)_____ Work #: (_____)_____ Cell #: (_____)_____
E-Mail: _____ Sex: Male / Female

SS#: _____-_____-_____ Date of Birth: ___/____/_____ Marital Status: S / M / D / Sep / W

Emergency Contact: _____ Phone: _____ Relation: _____

Referred By: □ Dr. _____ □ Family member _____
□ Friend _____ □ Other _____

Have you seen or heard any of our marketing efforts? Y / N If yes, circle all that apply
□ TV □ Radio □ Billboard □ Newspaper □ Brochures □ Magazines □ Other_____

ABOUT YOUR VISIT

Current complaint: _____

Do you have pain as result of accident or injury: Y / N If yes, date of accident or injury:_____

Please explain : _____

If no, date that pain was first noticed:_____

ABOUT YOUR EMPLOYER

Employer: _____

Employer Address:_____

City, State, Zip: _____ Phone #: _____

PRIMARY INSURANCE

Insurance Company Name:_____ Phone #: _____

Policy # _____Group #: _____

Policy Holder's Name: _____ SSN:_____ DOB: _____

Address if different from above:_____

SECONDARY INSURANCE

Insurance Company Name:_____ Phone #: _____

Policy # _____Group #: _____

Policy Holder's Name: _____ SSN:_____ DOB: _____

Address if different from above:_____

To the best of my knowledge the above information is true and correct.

I hereby give permission to Direct RehabMed, East Texas Spine Institute, PA, Ritesh R. Prasad MD, DRM Business Heath, PLLC, C Perry Marshall, MD, Coby Marrow, MPT, William Farrar, LPC, Racheal Cox, CCC-SLP, Occupational Rehab Management, Marrow GP Management, LLC, their agents, affiliated physicians or therapists, to examine and treat me as deemed medically necessary.

Signature: _____ **Date**: _____

Office Use Only	Front Desk_____	Data Entry_____	Scanned_____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION - IN

Patient's Name: _____Previous Name:_____

SS#: _____ Date of Birth: _____

Address: _____ Phone: _____

REQUESTED FROM:
I request and authorize _____

Address: _____

City, State, Zip Code: _____

To disclose or release the following information from my medical records:

- ❑ Complete medical record
- ❑ Treatment plans
- ❑ Psychiatric/Medical History
- ❑ Initial Assessment/Social History
- ❑ Progress Notes
- ❑ Other/Specify: _____

To:
- ❑ **Ritesh Prasad, MD**
- ❑ **C Perry Marshall, MD**
- ❑ **B. Coby Marrow, PT, MPT**

3110 Park Center Dr
Tyler, TX 75701
(903) 593-9999 ♦ (903) 526-2679 fax

We require that copies of medical records be sent single-sided on 8.5x11 paper unless otherwise noted.

The purpose or need for disclosure is: _____

I give permission to release copies of the records described above. I understand that the specific type of information to be disclosed may include drug, alcohol, or mental health. I understand I may revoke or cancel this authorization at anytime, with the exception that action has already been taken. This authorization will remain in effect for 180 days or the time period specified below, in order to carry out for which the permission was given. I understand that the program releasing these records is free from all liabilities that may arise from the act. I understand that I have the right to limit the information the information that is to be released and who can see the information.

This authorization will expire on: _____

_____ _____
Client Signature Date

_____ _____
Witness Date

REVOCATION OF CONSENT

I, _____ hereby revoke or cancel this authorization effective _____ (date).

_____ _____
Client Signature Witness

NOTICE TO RECEIPIENTS OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR part 2) prohibit you or you organization from making any further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulation. A general authorization or the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client/patient.
Mental Health: This information is released subject to the "Confidentiality" provision of TX. HS. Code 611 and Texas Rules of Evidence, Civil/Criminal Rules 510.

Requested By: _____

Health Record

Name: _____ **Male/Female** **DOB:** ____/____/____ **Age:** _____
Weight: _____ **Height:** _____
Source of Information: Self / Spouse / Parent / Other: _____

Current Complaints: _____
_____
Past Medical History: Chronic Illnesses: _____
_____
_____
Hospitalizations/Operations: _____
_____

OB/GYN: Pregnancies: _____ Births: _____ Abortions: _____ Living Child(ren): _____ LMP: ___/___/___
Menopause: Y / N If yes, date: ____/____/____ Hormone Replacement: _____
Bone Density Test: Y / N If yes, date: ____/____/____ Last Pap: ____/____/____
Last Mammogram: ____/____/____

Last Exams: Labs: ____/____/____ Prostate: ____/____/____ EKG: ____/____/____
Chest X-Ray: ____/____/____ Stress Test: ____/____/____ Colonoscopy: ____/____/____

Last Immunizations: Tetanus: ____/____/____ Influenza: ____/____/____ Pneumovax: ____/____/____
TB Skin Test: ____/____/____ Hepatitis A: ____/____/____ Hepatitis B: ____/____/____

Current Medications:
1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____
7) _____ 8) _____ 9) _____
Allergies: _____

Medical Providers/Specialists: (last 5 years)_____
_____

Social and Family History:
Marital Status: Single / Married / Separated / Divorced / Widowed Live with: _____
Occupation: (Current) _____ (Prior) _____
Children: # of boys _____ # of girls _____ Siblings: # of brothers _____ # of sisters _____

Parents: Father (alive / deceased) Health problems: _____
Mother (alive / deceased) Health problems: _____
Family History of Cancer: _____
Alcohol Consumption: Y / N Amount _____ / day / week / month Sobriety: _____ Yrs / Months
Smoke: Y / N _____ packs per day, for _____ years
Recreational Drug Use: Y / N Type: _____ Last used: _____

Patient Signature: _____ **Date:** _____

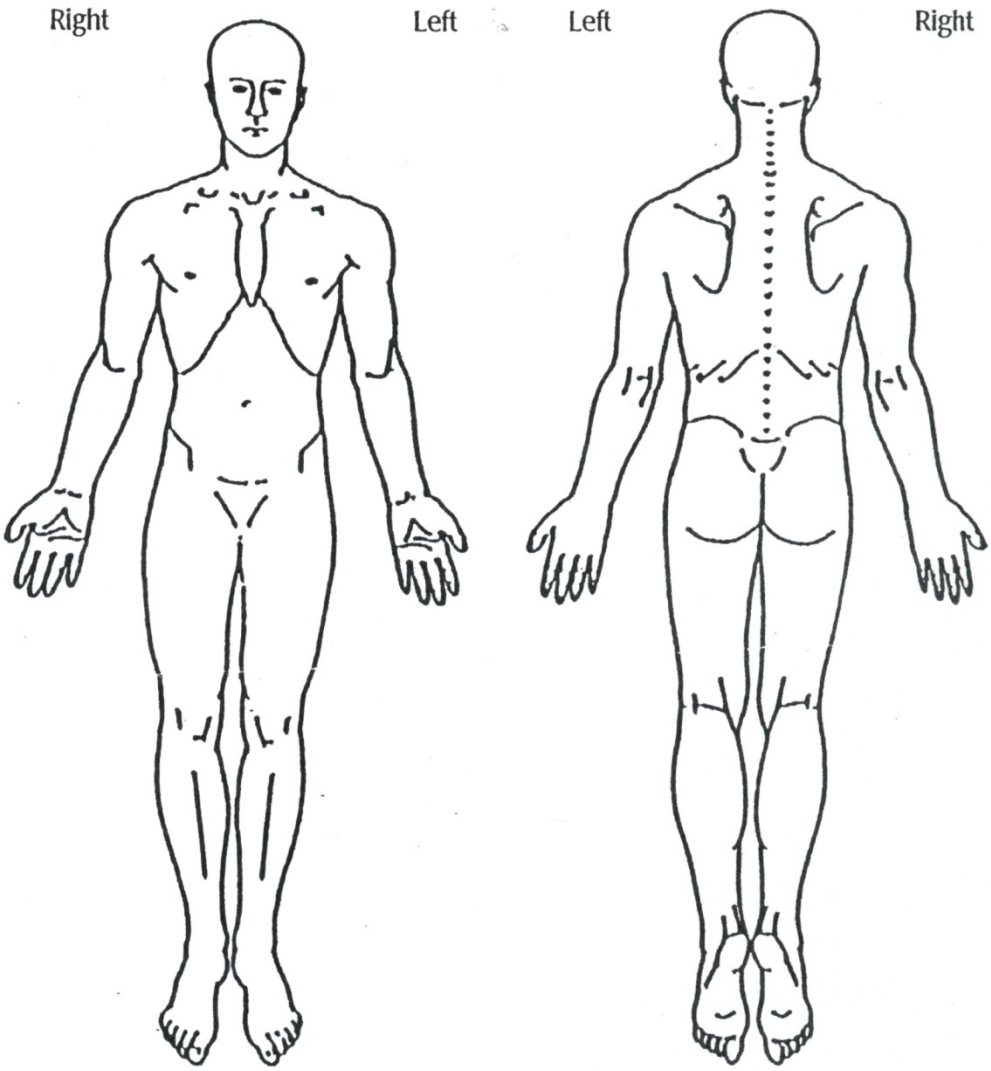
Physician Signature: _____ **Date:** _____

PAIN DOCUMENTATION

Name: _____ Date: _____

Mark the location(s) of your pain on the body outlines using the symbols.

Pins and Needles	= = = = = =
Stabbing	z z z z z z
Burning	B B B B B B
Numbness	x x x x x x
Aching and Cramping	/// /// /// ///
Other Sensations	o o o o o o



Is your pain ☐ Constant ☐ Intermittent

At what time(s) of the day does the pain occur or is at its worst?

What makes the pain better? (e.g., position)

I am currently:
- ☐ Working regular duty
- ☐ Working light duty
- ☐ Not working

On the line below, CIRCLE where your pain would be today.

0 No Pain | 1 | 2 Mild Pain | 3 | 4 Moderate Pain | 5 | 6 Severe Pain | 7 | 8 Very Severe Pain | 9 | 10 Worst Pain Possible (e.g. broken bone, childbirth, kidney stone)

What other doctor have you seen for your work injury since you last appointment here? When?

_____

_____

What procedures/surgeries have you had done since your last appointment here? What procedures/surgeries do you have scheduled? _____

_____

Medication Agreement & Refill Policy

As part of your treatment, our medical staff (**Ritesh R. Prasad, MD, C Perry Marshall, MD**, or any mid-level provider acting on their behalf, hereinafter referred to as **"Provider"**) ***may*** prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written for you unless you accept the following agreement. **Please check all boxes to acknowledge that you have read and agree to our medication policies.**

- ❑ I agree to follow the dosing schedule prescribed to me by my **"Provider."**
- ❑ I will never share, sell or exchange my medications with anyone for any reason.
- ❑ I understand that I am *solely* responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that **"Provider"** does not replace LOST OR STOLEN prescriptions or controlled medications.
- ❑ I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impair cognitive function.
- ❑ I agree to notify **"Provider"** if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to **"Provider"** for disposal.
- ❑ I agree that if I receive a controlled substance prescription from **"Provider"**, I am ***not*** allowed to accept controlled substance prescriptions from any other physician without **"Provider"** consent.
- ❑ I agree to use only one pharmacy for my pain-related medications. In the event, that circumstances require the use of another pharmacy, I will notify **"Provider"** of this immediately and provide them with all pertinent contact information.
- ❑ I understand that medication refill prescriptions involving narcotic pain medicine require a scheduled appointment with **"Provider"** in the office. **Narcotic pain medication refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.**
- ❑ **I agree to keep all scheduled appointments. I understand that no medications will be given for cancelled or no-show appointments.** I understand that if I am more than **15 minutes** late to my scheduled appointment time, I will have to reschedule for another time.
- ❑ I know that I can not be seen at the office without a scheduled appointment *for ANY reason.*
- ❑ The **"Provider"** phone triage hours are 8:00am to 4:00pm, Monday through Friday for Non-Emergency medication questions and refill requests. I acknowledge and agree that I will not call this line more than two times in any day.
- ❑ I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).
- ❑ I understand that **"Provider"** will write and dispense narcotic medication prescriptions on a 30 day basis. In order to receive another narcotic medication prescription I must schedule another office visit within 30 days of the date on my current prescription so my doctor can properly evaluate my progress.
- ❑ I understand that abusive behavior or harassment toward any **"Provider"** staff cannot be tolerated. The **"Provider"** will determine what actions can be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.
- ❑ I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from "Provider".
- ❑ I understand that **"Provider"** reserves the right to PERFORM A URINE DRUG SCREEN AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES. If the results of the urine drug screen do not reflect medicine prescribed by **"Provider,"** or test positive for illegal drugs, I understand that I can be dismissed immediately from the practice.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. Non-compliance with this agreement will be terms for dismissal from the practice.

_____ _____

Pharmacy Name and Address Pharmacy Phone Number

_____ _____

Signature Date

_____

Print Name

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ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

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Thank you for choosing us as your health care provider.
The following is a statement of our Financial Policy.

APPOINTMENTS

The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you.

Missed Appointments – Our policy is to charge for missed appointments or appointments cancelled with less than 24 hours notice. If you fail to keep a scheduled appointment with a provider, and do not give the office at least 24 hours notice of cancellation, you may be charged a missed appointment fee of $50.00. Insurance plans do not cover these fees; you will be billed directly for this. Failure to pay a no-show fee may be treated according to our policy on unpaid balances, with the exception of collection accounts. The number to call and cancel an appointment 24 hours a day is (903) 593-9999.

ALL PATIENTS MUST COMPLETE OUR "PATIENT DATA FORM"
BEFORE BEING SEEN AT DIRECT REHABMED.

All patients are expected to complete a patient information and financial responsibility form annually. An updated patient information form must be completed anytime there is a change. For Group Insurance patients, **A valid insurance card is required to be presented for copying at each visit.** Failure to provide correct information at the time of your visit may result in a delay in care and responsibility for the cost of the entire visit.

INSURANCE

Our practice accepts insurance from most major insurance companies. It is **YOUR responsibility to know your coverage and benefits.** As a courtesy, we will file your claim to the respective insurance company. To avoid any misunderstandings regarding payment for professional services, Direct RehabMed requests that you authorize all insurance company payment directly to our practice. If you choose not to do so, all charges will be due and payable by you at the time of service. You will be responsible for any portion of your bill which is denied, applied to deductible, considered a co-payment or co-insurance portion or is considered non-covered by your insurance plan. Working together we can resolve most insurance issues in a mutually acceptable and convenient manner.

WORKERS' COMPENSATION

If you are seeking treatment for a work related injury, we expect you to notify us that this injury was related to your job. We ask that you notify our office in advance of your appointment so that we can verify coverage for your care.

MEDICARE

Deductibles and 20% of the allowable charges are due at the time of service. As we are Medicare providers, we will file your insurance claims. Please bring your Medicare Explanation of Benefits (EOB) showing you have met your deductible.

PAYMENT OF FEES

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED. Any balance on your account over 60 days old, including those balances that insurance has not paid, will be due in full. All accounts over 120 days old will be turned over for collections. We realize that emergencies do arise and may affect timely payments of your account. If such extreme cases do occur please contact us promptly for assistance in the management of your account. Please understand that payment of your bill is considered a part of your treatment. You have the right to refuse any services rendered to you if you think they are non-covered services or not payable by your insurance company.

INSURANCE

We **cannot** waive co-payment, Deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with the various health plans. **Payment of co-payments and co-insurances are due at the time of the office visit.** Please be ready to make payment on the day you visit the office. Any remaining balance on your account after the insurance company has processed your claim is due upon receipt of a statement from our office. If a patient is a member of an insurance plan with which we do not participate, our office will also file a claim on the patient's behalf; however, the patient is expected to make payment in full at the time of service. Please contact your insurance company with any questions about your insurance coverage.

WORKERS' COMPENSATION

We will file your claim with your company's Workers' Compensation insurance carrier. In the event you fail to pursue the claim for Workers' Compensation (for this illness or condition) or it is determined by the Workers' Compensation Board that this illness or condition is not a compensable injury, you will be responsible for the payment of your balance due.

METHODS OF PAYMENT

Cash, personal check, Visa, MasterCard or American Express are accepted methods of payment to Direct RehabMed. **Return check fee is $25.00.**

Please let us know if you are having difficulty paying your account. We may be able to help by setting up a payment plan based on your financial condition, call (903) 595-3101 for assistance.

PAST DUE ACCOUNTS

All patient-responsible balances that remain delinquent after 120 days, with no response to your requests for payment, may be referred to a collection agency. Once an account is turned over to the collection agency, the patient or responsible party will have to settle the debt with the agency. Please be aware that if a balance remains unpaid, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30 day period, our providers will only be able to treat you on an emergency basis.

MEDICAL RECORDS

If in the future, should you need copies of your medical records, we do charge a $25.00 fee for this service. We require a written release of records to be signed and dated due to the HIPAA Law. It takes our office eight to ten business days in order to process a request so please plan ahead.

Thank you for understanding our financial policy. If you have any questions regarding your bill or the status of your account, please call Direct RehabMed at (903) 595-3101.

I have read and understand the financial policy of the practice and I hereby agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

As used above, the term Direct RehabMed shall mean Ritesh R. Prasad, M.D., East Texas Spine Institute, DRM Business Health, PLLC, C Perry Marshall, M.D., Direct RehabMed, Coby Marrow, P.T., William Farrar, LPC, and/or Racheal Cox, CCC-SLP.

Signed this _____ day of _____, 20____

_____ _____

PRINTED Patient/Parent/Guardian Name Accepted: Direct RehabMed

_____

SIGNED Patient/Parent/Guardian Name