TRAME VESTIBULAR REHAB, LLC
Patient Intake Form

Patient Information **Verified DL:** Yes No

Last Name: First Name: Middle Initial:

Address: City: State: Zip Code:

Home Phone: Cell Phone: Email Address:

Date of Birth: _____ SSN#: _____ Sex: ☐ Male ☐ Female Marital Status: _____

Employer Information

Employer Name: Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Address: City: State: Zip Code:

Work Phone Number: Patient Occupation:

Emergency Contact Information

Contact Name: Phone Number: Relationship to Patient:

Physician Information

Name of Referring Physician: _____ Telephone #: _____

Family Doctor: _____ Telephone #: _____

Additional Questions

Auto Related:	Work Related:	Accident Related:	Body Part/Diagnosis:	Date of Injury:
☐ Yes	☐ Yes	☐ Yes		
☐ No	☐ No	☐ No		

MEDICARE ONLY – Additional Questions

If Medicare, are you currently receiving Home Health Services? ☐ Yes ☐ No If yes, Name of Agency? _____

If Yes, what type of Home Health Services are you receiving? _____ Last date of service: _____

Are you currently residing in a Skilled Nursing Facility? ☐ Yes ☐ No If yes, Name of Facility: _____

If Medicare, have you received PT, OT or Speech therapy services since the first of the year? ☐ Yes ☐ No

-If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

TVR, LLC – continued Insurance Information – Page 2 ***

*****Only complete this section if the Primary or Secondary Policy is NOT the patient. Primary ☐ Secondary ☐**

***Last Name: First Name: Middle Initial: SSN: DOB:

_____

***Patient Relationship to Policy Holder: Gender ☐ Male ☐ Female

_____

***Employer Name: Employer Phone #

_____

Primary Insurance Section	**Secondary Insurance Section**
Payer / Plan	Payer / Plan
Policy / ID#:	Policy / ID#:
Group #:	Group #:

1) I **consent** to TRAME VESTIBULAR REHAB, LLC, for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to TRAME VESTIBULAR REHAB, LLC to exchange with and/or release requested information on my medical care to my insurance carrier(s) and to:

☐ Workers Compensation ☐ Patient/Guardian ☐ Physician ☐ Attorney ☐ Insurance Company

2) I certify that the information furnished by me is correct and here by **direct and authorize payment of health care benefits** due me by insurer to TRAME VESTIBULAR REHAB, LLC. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from TRAME VESTIBULAR REHAB, LLC.

_____ _____
Client's Signature Date

3) I have read and understood TRAME VESTIBULAR REHAB, LLC **privacy notice**.

_____ _____
Client's Signature Date

4) I understand that any remaining balance, after insurance payment, is my responsibility. In the event that payment is not made when due, TRAME VESTIBULAR REHAB, LLC may add 10% interest to that bill, and, may refer my account to a **collection agency.**

_____ _____ _____ _____
Client's Signature Date Witness Signature Date

_____ _____
Responsible Party's Signature (if patient is a minor) Date

Form revised July 13, 2017