BaylorScott&White
INSTITUTE FOR REHABILITATION
OUTPATIENT THERAPY

Consent to Treatment; Authorization to Release Information; and Statement of Financial Responsibility

Revised 08/01/2018

Patient Name:_____ **Date**:_____ **Acct#**:_____

BIR JV, LLP appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the center, mailed to the address on your statement, or you may access our on-line bill payment option @ **http://pay.instamed.com/BIR** once a statement is received from the billing office, or by calling our customer service department at 1-866-889-9968.

I have read the above policy regarding my financial responsibility to BIR JV, LLP for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to BIR JV, LLP. I agree to pay BIR JV, LLP the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier. *Patient Service Specialist Initials: _____*

Signature:_____(relationship to patient: self – guardian – other**:**_____) **Date:**_____

You agree that in order for us to collect any amounts you may owe, we may contact you by any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and use of automatic dialing devices, as applicable.

Signature:_____(relationship to patient: self – guardian – other**:**_____) **Date:**_____

**Please note that the information included in this *Statement of Financial Responsibility* form is subject to any applicable state laws, rules or regulations that impact your financial responsibility and whether there is an amount owed.

You will receive calls and/or text messages that deliver autodialed or pre-recorded telemarketing messages from an automatic telephone dialing system. You consent to receive such calls and/or texts at the telephone number associated with your account. Your consent to receive such calls and/or text messages is not a condition of any purchase of a service or product.

I/We have read this disclosure and agree that Provider, and/or their representative, may contact me/us as described above.

Signature:_____(relationship to patient: self – guardian – other:_____) **Date:**_____

I acknowledge that the Notice of Privacy Practices and Notice for Federal Civil Rights is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:**_____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I am aware of my diagnosis and voluntarily consent to have BIR JV, LLP, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical, speech, and occupational therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from BIR JV, LLP is limited to physical, speech, and/or occupational therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:** _____

I further authorize BIR JV, LLP to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:**_____

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INSTITUTE FOR REHABILITATION
OUTPATIENT THERAPY

PATIENT NAME:_____ **DATE:**_____ **ACCT#:**_____

NOTIFICATION of PATIENT RESPONSIBILITY for CO-PAYMENTS / CO-INSURANCE % and DEDUCTIBLES

Your insurance company requires BIR JV, LLP Rehabilitation to collect your co-payment amount from you at the time of service. If we do not collect these amounts we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment. Furthermore, we have an obligation to collect any co- insurance % or unmet deductible amounts from you that are determined to be your responsibility.

You will receive statements from us during and after your treatment for any outstanding amounts your insurance company indicates will be your financial responsibility. These statements will also include the amount billed to your insurance company and the payments received from both you and your insurance company**.**

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize BIR JV, LLP to disclose my health information that is directly related to my current treatment at BIR JV, LLP to the individual(s) listed below for purposes of their role in my treatment or payment or payment for the health services that I have received.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to individuals involved in my care.

NAME	RELATIONSHIP

BIR JV, LLP has verified Outpatient Physical Therapy/Occupational Therapy/Speech Therapy benefits based on the information furnished to us by you. Your Insurance Company has the disclaimer that this is verification of benefits and not a guarantee of payment. Based on the information your insurance company provided to us, the estimated amount you are responsible for is:

Co-Payment_____/Visit

Co-Insurance_____**%** of allowed amount

Deductible Amount_____ Amount Not Met _____

Maximum Visits/Days_____ Per Person / Condition / Year / Lifetime

Maximum Dollar Amount_____ Out of Pocket Maximum _____

Other Benefit Information _____

NOTE: ***ESTIMATED coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility of their account balance. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company***.

We are committed to Service Excellence to our patients. If you have questions or concerns about your billing, please contact our Centralized Business Office at (866) 889-9968. Thank you.

Baylor Scott & White
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OUTPATIENT THERAPY

Rev 2/20

Outpatient Medical History / Screening Form

To be completed by the patient

Patient Name:_____DOB: _____Age:_____Height:_____ Weight:_____

Why are you here?_____Date of Injury:_____

Spoken Languages: _____

Preferred language to receive healthcare information *for patient* :_____

Preferred language to receive healthcare information *for legal guardian / Healthcare Proxy* : _____

Family Physician/Internist:_____ Telephone #:_____

Religious / Cultural Needs: NO ☐ YES ☐ Please Explain:_____

Special Learning Needs: NO ☐ YES ☐

Hearing Difficulty: NO ☐ YES ☐

Speaking / Communication Difficulty: NO ☐ YES ☐

Medical Information:

History of:	YES	NO	Family History	Y	N
Diabetes	☐	☐		☐	☐
Hypertension (high blood pressure)	☐	☐		☐	☐
Heart Attack	☐	☐		☐	☐
Heart Disease	☐	☐		☐	☐
High Cholesterol	☐	☐		☐	☐
Smoking	☐	☐			
Chest Pain / Angina	☐	☐			
Light-Headedness / Dizziness / Fainting	☐	☐			
Hypotension (low blood pressure)	☐	☐			
Shortness of Breath	☐	☐			
Ankle Swelling	☐	☐			
Night Coughing	☐	☐			
Cancer / Tumors / Growths	☐	☐		☐	☐
Radiation / Chemotherapy Treatment	☐	☐			
Osteoporosis	☐	☐		☐	☐
Osteoarthritis	☐	☐		☐	☐
Rheumatoid Arthritis	☐	☐		☐	☐
Rheumatic Disease	☐	☐		☐	☐
Have you had / have a: Stroke	☐	☐		☐	☐
Multiple Sclerosis	☐	☐		☐	☐
Brain Injury	☐	☐			
Spinal Cord Injury	☐	☐			
Fractures / Total Joint Replacement	☐	☐			
DATE:_____ AREA:_____					
DATE:_____ AREA:_____					

	YES	NO
Diminished Sensation / Numbness	☐	☐
Skin Sensitivities:	☐	☐
Latex ☐ / Adhesives ☐ / Temperature ☐		
History of pressure sores	☐	☐
Pacemaker / Defibrillator	☐	☐
Bleeding / Bruising (recent history)	☐	☐
Hypoglycemia	☐	☐
Active seizure disorder	☐	☐
Dementia / Alzheimer's	☐	☐
Kidney Disease	☐	☐
Asthma	☐	☐
* Always have inhaler with you	☐	☐
Lung Disease / Emphysema / COPD	☐	☐
* Oxygen use	☐	☐
Are You Pregnant?	☐	☐
In the past month, have you frequently been bothered by feeling down, depressed or hopeless?	☐	☐
In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things?	☐	☐
Depression / Anxiety / Panic Attacks	☐	☐
Other: _____	☐	☐

In the past three months have you experienced:		
Changes or difficulty with Bowel	☐	☐
Changes or difficulty with Bladder	☐	☐
Night Sweats	☐	☐
Fever	☐	☐

Are you in pain?

Location of pain_____

If you answered yes to any of the above:

Are you under the care of an MD for these conditions?	YES	NO
	☐	☐

Allergies: _____

_____

Surgery(s) within last 3 months - Include Dates: _____

What are your Rehabilitation goals?:_____

Advanced Directives: If you need information regarding Advanced Directives, please contact the site Admission/Office Assistant. Advanced Directives are not honored in the Outpatient Setting.

FALL RISK ASSESSMENT*:	YES	NO
Have you fallen within the last year? If so, how many times? _____	☐	☐
Have any of these falls resulted in an injury within the last year?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady on your feet or in your wheelchair?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐
Do you use sedatives that affect your level of alertness during the day?	☐	☐
Do you have memory / cognitive difficulties?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐

AS PER CMS FALL SCREENING CRITERIA

***Patient is considered a fall risk if patient has fallen two or more times in the past year**

***Patient is considered a fall risk if patient has fallen one time with resulting injury in the past year**

NUTRITIONAL SCREENING	YES	NO
Unexplained weight loss? (>5% in last 30 days)	☐	☐
Recent loss of appetite/aversion to food?	☐	☐
Do you have difficulty swallowing?	☐	☐
Have you had a decrease in food intake?(<50% of typical intake > 3 days)	☐	☐
Are you under the care of a MD for these conditions?	☐	☐

CURRENT MEDICATION (List below)

I provided a separate list of medications: ☐

I am currently not taking any over the counter or prescribed medications / herbals: ☐

Are all meds prescribed by a physician? Yes ☐ No ☐

****Please inform your therapist of any changes in medications, medical conditions or surgeries so this summary list may be updated as you progress in your treatment*****

PATIENT SIGNATURE:_____ **DATE:**_____

If signature other than patient, relationship to patient (guardian / parent if minor):_____

To be completed by evaluating Therapist

** **FALL RISK** - Patient is considered a fall risk if they answer yes to three or more fall risk assessment questions, if they meet CMS screening criteria for fall risk, or if therapist judgment indicates. Clinician should refer to the Fall Prevention Policy PC OP 1018.*

Patient has been identified as a fall risk: YES ☐ NO ☐

If Yes, fall prevention program has been implemented: YES ☐ NO ☐

Patient has been identified as a nutrition risk : YES ☐ NO ☐ *If Yes, Notify MD*

Patient would benefit from a Social Services referral: YES ☐ NO ☐ (yes if therapist feels patient life is threatened, or if patient is a threat to others)

Therapist Signature: **Date:** **Time:**

Therapist Signature: **Date:** **Time:**

Therapist Signature: **Date:** **Time:**

UPDATES:

Please list changes to Medication:

Please list changes to medical condition/surgeries:

PATIENT SIGNATURE:_____ **DATE:**_____

THERAPIST SIGNATURE: _____ **DATE:**_____

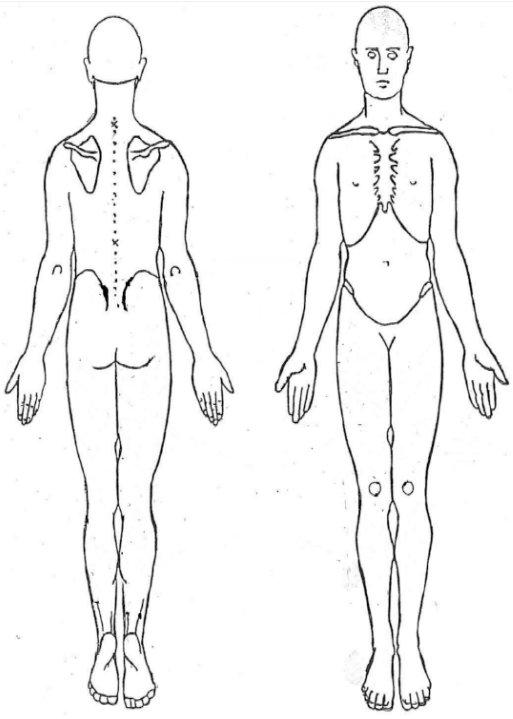
Name:_____ Date:_____

I HAVE PAIN: YES_____ NO_____ (If no skip to "Patient Specific Functional Scale" below)

Please use the diagram below to indicate where you feel symptoms right now.

Use the key below to indicate the different types of symptoms:

KEY: Pins & Needles = oooooo Stabbing = //////////
Burning = XXXXXX Deep Ache = ZZZZZZ



Please mark your ***best (B), current (C), and worst (W)*** level of pain or symptom on the following line:

0 1 2 3 4 5 6 7 8 9 10

(**0** = none →**10** = worst imaginable. Indicate level for each with B, C, and W)

1. What makes your pain or symptom worse?

_____

_____

2. What makes your pain or symptom better?

_____

_____

3. Are your symptoms: (check one)
☐Getting worse; ☐The same; ☐Improving

4. How are you able to sleep at night? (check one)
☐Fine; ☐Moderate Difficulty ; ☐Only with Medication

5. Do you have pain at night? ☐Yes … ☐ No

6. When (date) did your problem begin? _____

7. Have you been treated for this before? ☐Yes … ☐No

When? _____

How? _____

PATIENT SPECIFIC FUNCTIONAL SCALE :

(*First Time Use for This Case)* Identify up to three (3) important activities that you are unable to do or are having difficulty with as a result of your medical condition. Using the Scale below indicate your ability to perform these activities today.

(***0** = unable to perform →**10** = as able as pre-injury)*

1. Activity_____ 0 1 2 3 4 5 6 7 8 9 10

2. Activity_____ 0 1 2 3 4 5 6 7 8 9 10

3. Activity _____ 0 1 2 3 4 5 6 7 8 9 10