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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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.

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Minor Patient Waiver

By my signature below, I, as the parent or legal guardian give permission for _____, a minor, to attend and receive therapy treatments at Baylor Institute for Rehabilitation without a parent or legal guardian in attendance. I understand that Baylor Institute for Rehabilitation strongly advises a parent or legal guardian to be present at least for evaluations and treatments that include the anterior chest on females, and pelvic area on all minors.

By my signature below, I also release Baylor Institute for Rehabilitation from the responsibility of supervising my child in the public areas of the building complex.

Name (Print): _____

Signature: _____Date: _____

Witness: _____ Date: _____

~~~~~~

Additional for infant or incontinent children:

By my signature below, I, as the parent or legal guardian, give permission for the following individuals: _____

to change diapers for my child, _____, as needed during treatment sessions without a parent or legal guardian in attendance.

Name (Print): _____

Signature: _____Date: _____

Witness: _____ Date: _____
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Outpatient Pediatric Medical History

Patient Name: _____ **Spoken Language:** _____

Parent/Guardian: _____ **Telephone #:** _____

Pediatrician: _____ **Telephone #:** _____

Religious/Cultural Needs: _____

Special Learning Needs: _____

Why is the child here? _____

Do you feel the child is in pain? ☐ no ☐ yes location: _____

Has the child seen any of the following?

Medical Doctor	☐	Physical Therapist	☐
Psychiatrist/Psychologist	☐	Occupational Therapist	☐
Orthopedist	☐	Speech Therapist	☐
Optometrist/Opthamologist	☐	Neurologist	☐
Osteopath	☐	Chiropractor	☐
Early Intervention Services	☐	School Based Related Services	☐

Has the child EVER been diagnosed with any of the following?

Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Stroke
☐	☐	Heart Problems	☐	☐	Kidney Disease
☐	☐	High Blood Pressure	☐	☐	Anemia
☐	☐	Asthma/Breathing Problems	☐	☐	Epilepsy
☐	☐	Thyroid Problems	☐	☐	Seizures
☐	☐	Diabetes	☐	☐	Cerebral Palsy
☐	☐	Arthritis	☐	☐	Muscular Dystrophy
☐	☐	Depression	☐	☐	Spina bifida/myelomeningocele
☐	☐	Hepatitis	☐	☐	ADD/ADHD
☐	☐	Tuberculosis	☐	☐	Autism/PDD
☐	☐	Fracture	☐	☐	Other: _____
		Location: _____			

Please list any surgeries or hospitalizations: _____

_____ ☐ none

Please list any medications (prescription/over the counter): _____

_____ ☐ none

Diagnostic Imaging (x-rays, ultrasound, MRI, bone scans, etc.): _____

_____ ☐ none

Allergies: _____ ☐ none

Maternal/Birth History (if < 5 years old): ☐ Child > 5 years old

Medical problems/complications during pregnancy:

☐ No ☐ Yes Please specify: _____

Delivery by: ☐ Vaginal ☐ Caesarean

Full term pregnancy: Yes ☐

No ☐ _____ weeks

Developmental History (if < 5 years old): ☐ Child > 5 years old

	Age (months)		Age (months)
Roll stomach to back	_____	Sit without assistance	_____
Roll back to stomach	_____	Pull to stand	_____
Crawl (on belly)	_____	Cruise	_____
Creep (on hands and knees)	_____	Walk	_____

Fine Motor Difficulties: _____

(i.e. holding a crayon/pen/pencil, self feeding, etc.)

Oral Motor Difficulties: _____

(i.e. swallowing, excessive drooling, feeding issues, etc.)

Speech difficulties: _____

Sleeping Concerns: _____

Immunizations: ☐ Current for age

☐ Child has not received immunizations

Parent/Patient Areas of Concern:

1. _____
2. _____
3. _____

Rehabilitation Expectations: _____

Patient Signature: _____ Date: _____

(Parent or guardian if under 18)

Clinician Signature: _____ Date: _____

Time: _____

Clinician Signature: _____ Date: _____

Time: _____

Clinician Signature: _____ Date: _____

Time: _____