

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

Revised 3/1/2020

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:** _____ **Time:** _____

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:** _____ **Time:** _____

**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:** _____ **Time:** _____

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:** _____ **Time:** _____

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 therapy, speech therapy, occupational therapy, and neuropsychology 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 therapy, speech therapy, occupational therapy, and/or neuropsychology 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:** _____ **Time:** _____

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:** _____ **Time:** _____

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.

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		YES		NO	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diminished Sensation / Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Sensitivities:	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex <input type="checkbox"/> / Adhesives <input type="checkbox"/> / Temperature <input type="checkbox"/>			
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of pressure sores	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker / Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding / Bruising (recent history)	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	
Light-Headedness / Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Active seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Hypotension (low blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dementia / Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Night Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	* Always have inhaler with you	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer / Tumors / Growths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease / Emphysema / COPD	<input type="checkbox"/>	<input type="checkbox"/>	
Radiation / Chemotherapy Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	* Oxygen use	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are You Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COVID-19	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In the past month, have you frequently been bothered by feeling down, depressed or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had / have a:							Depression / Anxiety / Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Fractures / Total Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
DATE: _____ AREA: _____										
DATE: _____ AREA: _____										

<p>In the past three months have you experienced:</p> <p>Changes or difficulty with Bowel <input type="checkbox"/> <input type="checkbox"/></p> <p>Changes or difficulty with Bladder <input type="checkbox"/> <input type="checkbox"/></p> <p>Night Sweats <input type="checkbox"/> <input type="checkbox"/></p> <p>Fever <input type="checkbox"/> <input type="checkbox"/></p>	<p>Are you in pain?</p> <p>Location of pain _____</p> <p>If you answered yes to any of the above:</p> <p>Are you under the care of an MD for these conditions? YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
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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*:	NUTRITIONAL SCREENING
YES NO	YES NO
Have you fallen within the last year? <input type="checkbox"/> YES <input type="checkbox"/> NO	Unexplained weight loss? <input type="checkbox"/> YES <input type="checkbox"/> NO
If so, how many times? _____	(>5% in last 30 days)
Have any of these falls resulted in an injury within the last year? <input type="checkbox"/> YES <input type="checkbox"/> NO	Recent loss of appetite/aversion to food? <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you afraid of falling? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have difficulty swallowing? <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you recently felt unsteady on your feet or in your wheelchair? <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had a decrease in food intake?(<50% of typical intake > 3 days) <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you experience dizziness or vertigo? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you under the care of a MD for these conditions? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have vision problems that are not corrected by glasses? <input type="checkbox"/> YES <input type="checkbox"/> NO	CURRENT MEDICATION (List below)
Do you use sedatives that affect your level of alertness during the day? <input type="checkbox"/> YES <input type="checkbox"/> NO	I provided a separate list of medications: <input type="checkbox"/>
Do you have memory / cognitive difficulties? <input type="checkbox"/> YES <input type="checkbox"/> NO	I am currently not taking any over the counter or prescribed medications / herbs: <input type="checkbox"/>
Do you have a lower extremity disability that affects walking? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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	
	Are all meds prescribed by a physician? YES <input type="checkbox"/> NO <input type="checkbox"/>
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: _____ TIME: _____	
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 <input type="checkbox"/> NO <input type="checkbox"/>	
If Yes, fall prevention program has been implemented: YES <input type="checkbox"/> NO <input type="checkbox"/>	
Patient has been identified as a nutrition risk : YES <input type="checkbox"/> NO <input type="checkbox"/>	*If Yes, Notify MD*
Patient would benefit from a Social Services referral: YES <input type="checkbox"/> NO <input type="checkbox"/> (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: _____ TIME: _____	
THERAPIST SIGNATURE: _____ DATE: _____ TIME: _____	

Name: _____

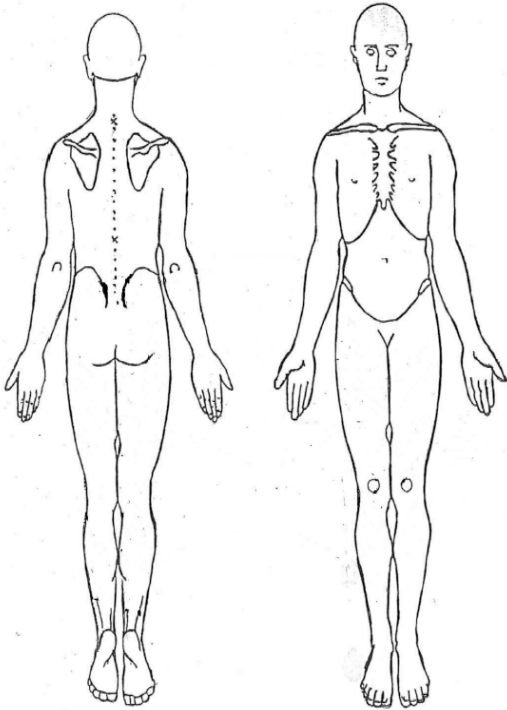
Date: _____

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 = 0000000 Stabbing = ///////////////
Burning = XXXXXX Deep Ache = ZZZZZZZ



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