Statement of Financial Responsibility

Patient Name: _____ Date: _____Acct :_____

BIR JV, LLP including; Out-Patient, In-Patient and, Home Health Rehab 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 on receipt of a bill 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. 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 system @ **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. Baylor Rehab offers financial assistance to those that qualify. Details and applications may be obtained from the Patient Service Specialist at the facility.

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. I understand I am financially responsible to BIR JV, LLP for charges not covered by this authorization. **MEDICARE PATIENTS:** I understand that this BIR JV, LLP facility is a provider-based location of the main hospital located in Dallas, Texas and that I may be responsible for a separate and additional coinsurance payment if I am seen by a physician at any BIR JV, LLP hospital, which I would not incur if this outpatient facility was not a provider based location of the hospital. The actual liability will depend on the actual services furnished by the hospital based on the current charge master. The estimated charges for visits to the facility are $275 - $400. (**MEDICARE:** Amount based upon typical or average charges. Please note that your final costs may be higher or lower, as this is only an estimate)

Signature: _____ **Date**: _____ **Time: _____**
(Relationship to patient: self - - guardian - - other: _____) **PSS Initials**: _____

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 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

I acknowledge that the **Notice of Privacy Practices** 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: _____ **Date**: _____ Time**: _____**
(Relationship to patient: self - - guardian - - other: _____)

Statement of Financial Responsibility

Patient Name: _____ Date: _____Acct :_____

Revised

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize BIR JV, LLP through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.
Signature_____ **Date**: _____ Time**: _____**
(Relationship to patient self—guardian—other: _____)

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: _____ **Date**: _____ **Time: _____**
(Relationship to patient: self - - guardian - - other: _____)

RESEARCH: Research to improve patient care is conducted at this hospital and is approved and monitored by the Institutional Review Board. This review and monitoring assures strict confidentiality with regard to who may view medical records. I consent to the use of information in my record for research purposes. I understand that I might subsequently be asked if I would be willing to participate in research projects if they require activities outside of normal clinical care, and that I have the right to decline participation.

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

Medical and Surgical Consent: I consent to BIR JV, LLP to provide me with necessary medical services, treatments and diagnostic tests. My consent to treat includes any examinations, X-rays, laboratory procedures, tests, medications, medical treatment, and/or other services rendered by the attending physician or other treating or consulting physicians, their associates, technical assistants and other healthcare providers including nurses and other hospital personnel, which in the judgment of such practitioners, are advisable during the course of evaluation, diagnosis and treatment. I consent to allow medical residents, students and authorized individuals to observe or participate in the care provided as determined by the treating physicians and as permitted by hospital policy.

Physicians and Independent Contractors: I understand that the physicians participating in my care at BIR JV, LLP are not employees or agents of BIR JV, LLP and are not acting for or on behalf of BIR JV, LLP. They are either independent physicians who are engaged in the private practice of medicine and who have been granted privileges to use this facility to care for their patients or they are licensed physicians who are engaged in a post-graduate medical education program. I understand that all such medical decisions regarding my care and treatment at BIR JV, LLP are made by such physicians and not by BIR JV, LLP.

Accidental Exposure of the Healthcare Worker: I understand that Texas law provides, if any healthcare worker is exposed to the patient's blood or other bodily fluid, that BIR JV, LLP may perform test(s) on the patient's blood or other bodily fluid to determine the presence of human immunodeficiency virus (HIV, the virus associated with AIDS). I consent to the testing for other communicable diseases, including but not limited to hepatitis and syphilis, in the event of an accidental exposure to a healthcare worker. I understand that such testing is necessary to protect those who will be caring for the patient while a patient of BIR JV, LLP.

Authorization to Photograph: I grant permission to photograph the Patient for the purpose of patient identification.

_____ _____

Signature of Patient Or Legally Authorized Representative Date Time Witness Date Time

Revised

Baylor Scott & White
INSTITUTE FOR REHABILITATION
OUTPATIENT THERAPY

Outpatient Medical History / Screening Form

To be completed by the patient

Patient Name:_____ Age:_____ Height:_____ Weight:_____

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

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

Emergency Contact:_____ Telephone #: _____

Family Physician/Internist:_____ Telephone #:_____

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

Special Learning Needs: NO ☐ YES ☐ Please Explain: _____

Hearing Difficulty: NO ☐ YES ☐ Speaking / Communication Difficulty: NO ☐ YES ☐

Why are you here?_____ Date of Injury: _____

Medical Information:

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

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? _____

Medical Information:

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?	☐	☐
Decrease in food intake?(<50% for 3 days or more)	☐	☐
Are you under the care of a MD for these conditions?	☐	☐

CURRENT MEDICATION (List below)

I provided 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 ☐

* ***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 in the OP KRC P&P manual (PC OP 1018).*

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

PATIENT SIGNATURE:_____DATE:_____

UPDATES:

Please list changes to Medication:

Please list changes to medical condition/surgeries:

PATIENT SIGNATURE:_____NEW DATE:

This information will be used as a guide to your treatment plan. If you need any medical follow-up, please contact your physician.

To be completed by evaluating Therapist

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:**

(Therapist has reviewed medical history form with patient)

Medical Screening Form

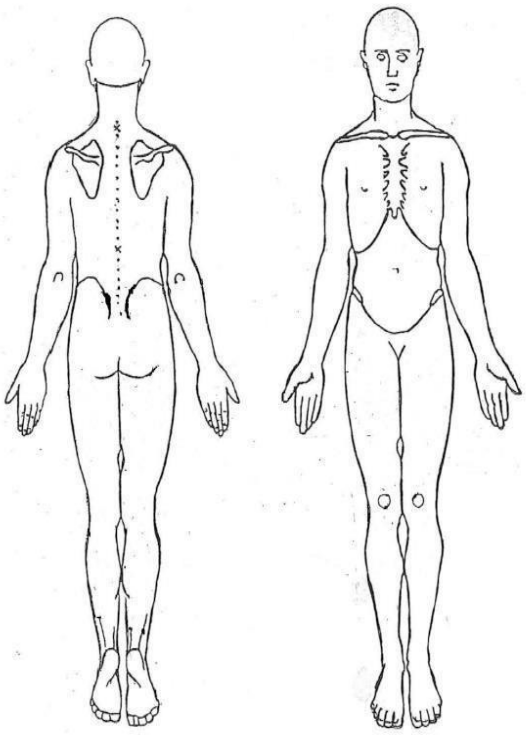
Name:_____ Date:_____

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 = 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