BaylorScott&White
INSTITUTE FOR REHABILITATION
OUTPATIENT THERAPY

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: _______________________)

BaylorScott&White INSTITUTE FOR REHABILITATION OUTPATIENT THERAPY

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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 Date Time Witness Date Time
Or Legally Authorized Representative

Revised

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OUTPATIENT THERAPY

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: _________________

© SelectMark
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BaylorScott&White
INSTITUTE FOR REHABILITATION
OUTPATIENT THERAPY

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
☐	☐	Arthrtitis	☐	☐	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 (precription/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: __________