BEAR CANYON THERAPY ASSOCIATES

5130 San Francisco NE · Suite B · Albuquerque, NM 87109 · 505.823.2411 · 505.858.0650

NEW PATIENT INFORMATION. (Fields marked with an * are **not** required)

DATE: ________________________

NAME: ____

ADDRESS: ____

CITY: _______________________________________ STATE: _____________ ZIP CODE: ________________________

HOME PHONE:_______________ CELL PHONE: _______________ EMAIL:____

DATE OF BIRTH: ______________ SEX (PLEASE CIRCLE): MALE FEMALE *SOCIAL SECURITY: ____________________

EMPLOYER: ____ WORK PHONE: ________________________

OCCUPATION: ____

RESPONSIBLE PARTY FOR PATIENT: __________________________________ TELEPHONE: __________________________

PRIMARY INSURANCE COMPANY: ____

SECONDARY INSURANCE COMPANY: ____

REFERRING PHYSICIAN: ______________________________________

BRIEF DESCRIPTION OF PHYSICAL COMPLAINT / INJURY / ACCIDENT: ____

CANCELLATION POLICY

Please call 24 hours in advance of canceling an appointment. The clinic reserves the right to assess a $25.00 fee for canceling less than 24 hours in advance or failing to attend a scheduled appointment.

EMERGENCY CONTACT INFORMATION

NAME:____ RELATIONSHIP: _______________________

TELEPHONE 1: ____ TELEPHONE 2: ________________________

RELEASE OF INFORMATION

I hereby authorize my physician to release any medical information to this facility upon request. I certify the above information to be true and correct to the best of my knowledge. I will notify this facility of any changes to the above information.

I hereby authorize Bear Canyon Therapy Associates to furnish information to insurance carriers concerning my illness and treatments and I hereby assign Bear Canyon Therapy Associates all payments for medical services rendered to me or my dependents.

I have been informed of my insurance benefits and eligibility and I understand that I am responsible for the deductible/co-pay/co insurance in accordance with my insurance policy and for services not covered by my insurance.

Signature of Patient/Responsible Party: _____________________________ **Date**: _________________________

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PATIENT HEALTH HISTORY

PATIENT NAME: ______________________________ DATE COMPLETED: ______________

To provide the best care possible, we need to know if you have or previously had any of the following conditions:

YES	NO	
____	____	Arthritic Condition.
____	____	Asthma or other breathing problems?
____	____	Cancer or Tumors of any type
____	____	Chest Pain
____	____	Diabetes: If yes, are you insulin Dependent? ______
____	____	Dizziness
____	____	High Blood Pressure
____	____	Irregular Heartbeat
____	____	Stroke
____	____	Seizures, Epilepsy, or Nervous Disorders
____	____	Are you pregnant?
____	____	Are you now or have you been an IV drug user?
____	____	Are you HIV positive?
____	____	Are you over 65?
____	____	Are you used to vigorous exercise?
____	____	Do you have joint replacements or metal implants?
____	____	Do you have any healing fractures?
____	____	Do you have bowel or bladder control problems?

Allergic conditions: ____

Do you smoke? ___________________________ Packs per day?___________

Diagnostic Tests (please provide date): X-Rays/MRI: ________ Injections: ________

EMG: ________ CT Scan: ________ Myelogram: ________ Other: ___________________

Have you had previous Physical Therapy Treatment? If yes, where and how long for:

____

Chiropractic treatment: ____________________ Work Hardening/Conditioning: ____________________

Assistive Devices: ____

Back/Neck Pillows: ____________________________ Back Brace/Belt: ______________________

List any condition you have not listed above: ____

____

Current Medications: ____

Do you have anything not listed above that prevents you from exercising? If yes, please explain:

____

I attest the above information is true and correct.

____ ____________________________

Signature of Patient/Responsible Party **Date**

Revised: 08/2011

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PATIENT'S BILL OF RIGHTS

The New Mexico Association for Rehabilitation Agencies states your rights as a patient are as follows:

1. You have the right to be fully informed by the clinical agency of all your rights.
2. You have the right to appropriate and professional care relating to physician's orders.
3. You have the right of choice of care providers.
4. You have the right to receive information necessary to give informed consent prior to the start of any treatment or procedure.
5. You have the right to refuse treatment within the confines of the law and to be informed of the consequences of your actions.
6. You have the right to privacy.
7. You have the right to receive a timely response from the agency to your request for service.
8. You shall be admitted for service only if the agency has the ability to provide safe and professional care at the level of intensity needed. You have the right to reasonable continuity of care.
9. You have the right to be informed within a reasonable time of anticipated termination of service or plans for transfer to another facility.
10. You have the right to voice grievance and suggest changes in service or staff without fear of restraint or discrimination.
11. You have the right to be fully informed of agency policies and changes for services, including eligibility for third party reimbursements.
12. If you are denied services solely on your inability to pay, you have the right to be referred elsewhere.
13. You (and the public) have the right to be honest, accurate information regarding the rehabilitation industry in general and your agency in particular.

The State Home Health Care (Rehabilitation Agencies) Agency hotline number is 1-800-752-8649. Please feel free to call this number if you have any concerns about your care.

I have read the above patient/clinic rights and have discussed these with the therapist.

X ______________________________ X ____________________

Patient/Responsible Party Date

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ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

By signing this page you acknowledge that you have received a copy of our Notice of Privacy Practices

Name of Patient: ____

Signature of Patient: ____

If signing on behalf of the patient:

Patient Representative Name (please print): ___________________________

Patient Representative Signature: ________________________________

Date: ____

Witnessed by (print name): _____________________________________

If you would like to give permission to a spouse/family member to obtain a copy of your medical records on your behalf, please ask for a Medical Records Release Form

Or

I authorize ______________________ , ______________________
(Name of authorized person) (Relationship to patient)

to obtain my medical records on my behalf.

Signature of patient: ____________________ Date Signed: ____________

You may revoke this authorization at any time. Should you wish to do so, please let a member of our staff know.

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PATIENT CONSENT TO TREAT AND BILL

Patient Name: ____
(First) **(Middle)** **(Last)**

I, as the Patient or responsible party for the Patient, authorize treatment by the payment of medical benefits to RAINBOW'S PROMISE THERAPIES, LLC d.b.a. BEAR CANYON THERAPY ASSOCIATES (BCTA) for therapy services rendered as ordered by the Patient's physician. I understand that BCTA will "TAKE ASSIGNMENT" of all Medicare and Insurance benefits payable with respect to all services rendered. I further authorize BCTA to furnish medical and other information requested in connection with any claims incurred for a period one (1) year pursuant to Title XVIII of the Social Security Act.

I further authorize BCTA, as a Medicare Provider, to bill Medicare for therapy services rendered to the Patient and to bill 20% of incurred charges to a co-insurance carrier.

I understand that BCTA is a licensed Out Patient Agency, and ACKNOWLEDGE that BCTA...

1. has given me and I have read a copy of the Patient's Bill of Rights;
2. will provide the Patient with Physical, Occupational and/or Speech Therapy on referral of the Patient's physician;
3. is responsible for provision and supervision of services provided by it;
4. will submit invoices to the appropriate insurer or third party payor for payment of its charges for services rendered to the Patient, and submit invoices to the Patient or responsible party of any amount not paid by such insurer, including any deductible or co-insurance amount;
5. will make available on request its current charges for Physical, Occupational and Speech Therapy;
6. has given me and I have read a copy of the Patent Complaint Procedure explaining the procedures to follow if I have a complaint;
7. will provide a certified social worker to help with non-medical needs that have arisen as a result of the illness if needed. Please circle requirement YES NO

______________________________ ______________

Signature of Patient or Responsible Party **Date**

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.**
Ask us to explain, if you don't understand why Medicare won't pay.
Ask us how much these items or services will cost you (**Estimated Cost: $**_____________).

Medicare will not pay for: _Physical Therapy and Speech-Language Pathology______ Services over $2230 for 2023

☐ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion * from Medicare benefits:**

- ☐ Personal comfort items.
- ☐ Most shots (vaccinations).
- ☐ Hearing aids and hearing examinations.
- ☐ Most outpatient prescription drugs.
- ☐ Orthopedic shoes and foot supports (orthotics).
- ☐ Health care received outside of the USA.
- ☐ Services required as a result of war.
- ☐ Routine physicals and most tests for screening.
- ☐ Routine eye care, eyeglasses and examinations.
- ☐ Cosmetic surgery.
- ☐ Dental care and dentures (in most cases).
- ☐ Routine foot care and flat foot care.
- ☐ Services by immediate relatives.
- ☐ Services under a physician's private contract.
- ☐ Services paid for by a governmental entity that is not Medicare.
- ☐ Services for which the patient has no legal obligation to pay.
- ☐ Home health services furnished under a plan of care, if the agency does not submit the claim.
- ☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- ☐ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- ☐ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- ☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- ☐ Services of an assistant at surgery without prior approval from the peer review organization.
- ☐ Outpatient occupational and physical therapy services furnished incident to a physician's services.

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

_______________________________ Signature

_______________________ Date

Bear Canyon Therapy Associates

Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing specialist. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. We accept cash, check, Mastercard, Visa, Discover, and American Express for your convenience.

Your Insurance
We have made prior arrangements with many insurers and other health plans to accept assignment of benefits. We will bill those plans which we have contracted with and will only require you to pay the authorized co-payment and deductible at the time of service. It is the policy of our office to collect the co-payment and unmet deductible if applicable when you arrive for your appointment.

Any unmet deductibles and/or balances remaining after your insurance has paid are your financial responsibility. **Verification of benefits is not a guarantee of payment**. In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge.

For all services rendered to minor patients, we will look to the adult accompanying the patient, parent or guardian with custody for payment.

I have read and understand the financial policy of Bear Canyon Therapy Associates and I agree to be bound by its terms. I agree that should I fail to pay any amount due, I will be responsible for any collection and/or attorney fees. I also understand and agree that such terms may be amended from time to time by the practice.
***A $25 late fee will be applied on all accounts 30 days past due.**

______________________________________ ____________________
Signature of Patient or Responsible Party **Date**

You can expect to receive a monthly statement while receiving treatment at this facility, detailing all transactions and notifying you of any balance due

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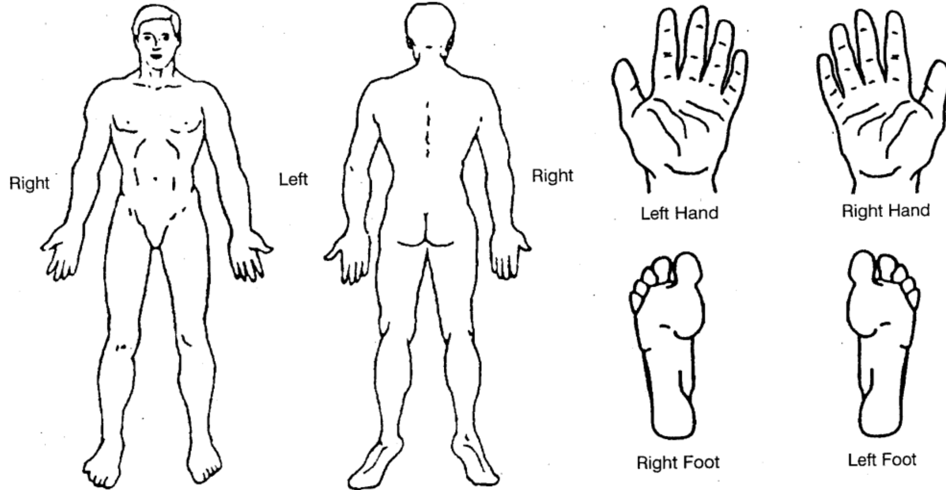
PATIENT NAME: ___________________________ **DOB:**______________ **THERAPIST:** _________________**DATE:** __________

PAIN PROFILE

Mark an "X" on the drawing below, the locations where you have experienced pain **in the last week.**

Grade each "X" using the following scale:

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating



Have you had this problem/injury before? Yes No

If yes, approximate dates:____

What makes your pain better? ____

What makes your pain worse? ____

Is your pain: ☐ **Getting better?** ☐ **Getting worse?** ☐ **Staying the same?** ☐ **Constant?** ☐ **Intermittent?**

With this condition, when did your pain start? ______________________________________

What is your goal in therapy? ____

Do you have any special learning needs? **PLEASE MARK ALL THAT APPLY:** ☐ **No** ☐ **Yes Visual**______________________ ☐ **No** ☐ **Yes Hearing**______________________ ☐ **No** ☐ **Yes Reading**______________________ ☐ **No** ☐ **Yes Learning**______________________ ☐ **No** ☐ **Yes Speech** ______________________ ☐ **No** ☐ **Yes Other**______________________	**Would you like any specific information related to your accident / illness / injury?** **PLEASE MARK ALL THAT APPLY:** ☐ **No** ☐ **Yes Equipment**____________________ ☐ **No** ☐ **Yes Community Resources**____________ ____ ☐ **No** ☐ **Yes Other**_________________________

Is there anything else we should know about that may affect treatment and/or progress? (i.e. language barriers, cultural or religious beliefs, scheduling or transportation issues) ____

____

Do you have any questions at this time about how to obtain further treatment following future discharge from therapy?

____

Patient Signature: _______________________ **Date:** ____________ **Therapist Signature:**____________________ **Date:** ___________

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Patient Medication List

Name: ________________________________ Date: __________________

Medication	Dosage	Frequency	Duration

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CALCIUM

Calcium is the most abundant mineral in the human body and is essential for many body functions. Calcium helps maintain a healthy skeleton, teeth, heart, muscles, and nerves to function properly. Bone undergoes continuous remodeling, with constant resorption (breakdown of bone) and deposition of calcium into newly deposited bone (bone formation). Getting enough calcium helps protect your bones by slowing the rate of bone loss and decreasing your risk for osteoporosis.

Recommended TOTAL Daily Calcium Intake from Food and Supplements

Age 9-18	1300 mg
Age 19-50	1000 mg
Age 51 and older	1000 mg -1200 mg

Calcium supplements are one way to increase your daily intake of calcium. There are many brands of calcium supplements these are a few examples.

Caltrate 600	600 mg
Citracal	400 mg
Oscal	250mg or 500mg
Tums Ultra	800mg
Tums EX	600 mg
Tums Regular	400mg
Viactiv	500 mg

Food Sources of Calcium

Milk 2% or 1%	1 Cup	285-290 mg
Skim Milk	1 Cup	300 mg
Soy Milk fortified	1 Cup	300 mg
Almond Milk fortified	1 Cup	300-400 mg
Cheese American	1 Slice	100 mg
Cottage cheese	½ Cup	150 mg
Cheese Mozzarella part skim	1 ounce	207 mg
Cheese Swiss	1 ounce	250 mg
Ice cream	1 Cup	176 mg
Pudding – Ready To Eat	4 ounces (1/2 cup)	100 mg
Yogurt	1 Cup	250-350 mg
Salmon canned w/ bones	5 ounces	300 mg
Juice calcium fortified	1 Cup	350 mg
Almonds	1 ounce (24 nuts)	70 mg
Broccoli raw/cooked	1 Cup	172 mg
Carrots raw	1 Medium	27 mg
Spinach cooked/frozen	1 Cup	164 mg
Sardines canned/bones	3oz	165 mg
Whole Grain TOTAL Cereal	¾ cup	1100 mg

Vitamin D

Vitamin D helps form and maintain strong bones by helping your body absorb calcium. The recommended dietary allowance for Vitamin D is between 400 to 1000 IU per day. Vitamin D can be produced in the body after careful exposure of the arms and legs to sunlight 10-15 minutes per day. Natural sources of Vitamin D can be found in fortified milk, eggs yolks, saltwater fish and liver.