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**: _________________________

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

Would you like us to email your statement to you? _____Yes _____No

If yes, please provide an email address ____

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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?

YES	NO	**MEDICARE PATIENTS ONLY**
____	____	Are you aware of your diagnosis?
____	____	Are you aware of your prognosis?

What type of diet are you consuming? Regular____ Soft____ Puree____ Tube Feeding____
What was the onset of your symptoms or injury (month/year)? ______________________

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 the following? If yes, where (if applicable) and for how long:

Physical Therapy Treatment: ____

Chiropractic treatment: ____________________ Work Hardening/Conditioning: ____________________

Assistive Devices: ____

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

List any condition you have not listed above: ____
____

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**

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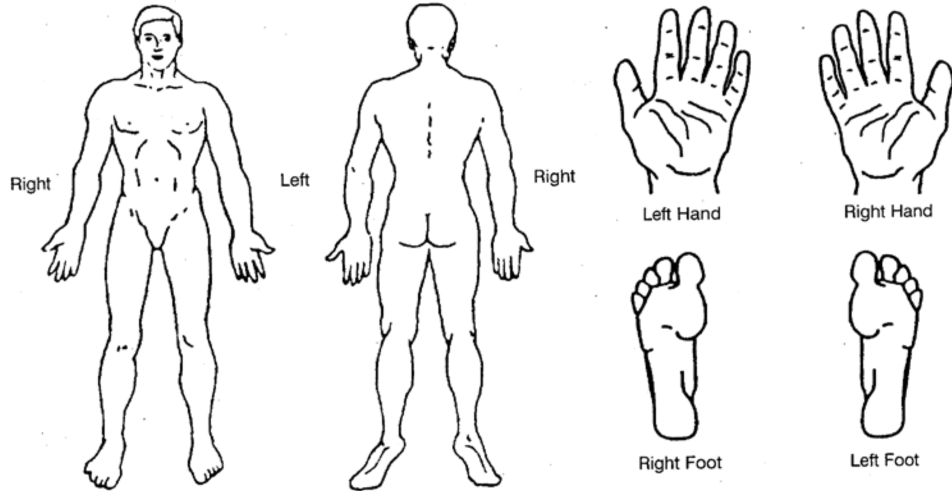
PATIENT NAME: __________________________ DOB:______________ THERAPIST: _________________DATE: __________



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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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.