



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



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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

Patient/Responsible Party

X

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 \$2150 for 2022

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

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

- | | |
|---|--|
| <input type="checkbox"/> Personal comfort items. | <input type="checkbox"/> Routine physicals and most tests for screening. |
| <input type="checkbox"/> Most shots (vaccinations). | <input type="checkbox"/> Routine eye care, eyeglasses and examinations. |
| <input type="checkbox"/> Hearing aids and hearing examinations. | <input type="checkbox"/> Cosmetic surgery. |
| <input type="checkbox"/> Most outpatient prescription drugs. | <input type="checkbox"/> Dental care and dentures (in most cases). |
| <input type="checkbox"/> Orthopedic shoes and foot supports (orthotics). | <input type="checkbox"/> Routine foot care and flat foot care. |
| <input type="checkbox"/> Health care received outside of the USA. | <input type="checkbox"/> Services by immediate relatives. |
| <input type="checkbox"/> Services required as a result of war. | <input type="checkbox"/> Services under a physician's private contract. |
| <input type="checkbox"/> Services paid for by a governmental entity that is not Medicare. | |
| <input type="checkbox"/> Services for which the patient has no legal obligation to pay. | |
| <input type="checkbox"/> Home health services furnished under a plan of care, if the agency does not submit the claim. | |
| <input type="checkbox"/> Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997. | |
| <input type="checkbox"/> 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). | |
| <input type="checkbox"/> 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. | |
| <input type="checkbox"/> 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. | |
| <input type="checkbox"/> Services of an assistant at surgery without prior approval from the peer review organization. | |
| <input type="checkbox"/> 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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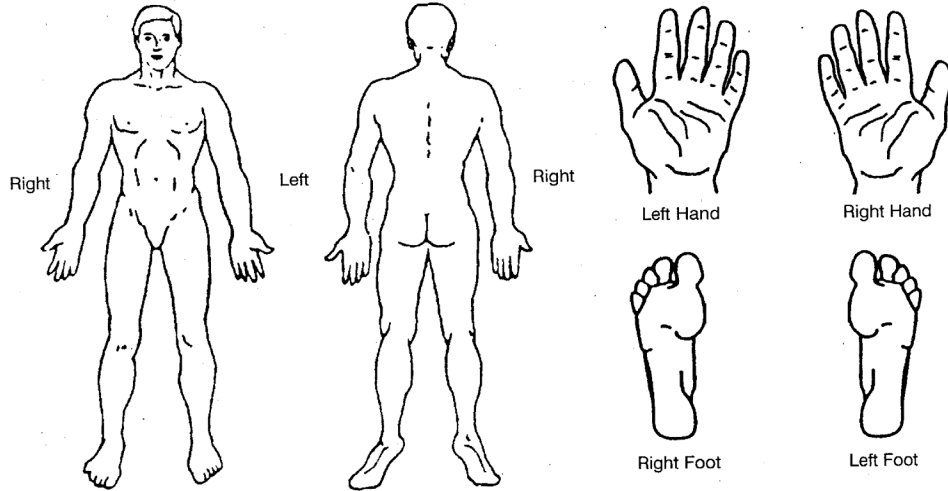
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PATIENT NAME: _____ DOB: _____ THERAPIST: _____ DATE: _____

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? _____

<p>Do you have any special learning needs? PLEASE MARK ALL THAT APPLY:</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Visual _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Hearing _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Reading _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Learning _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Speech _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Other _____</p>	<p>Would you like any specific information related to your accident / illness / injury? PLEASE MARK ALL THAT APPLY:</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Equipment _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Community Resources _____</p> <p>_____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Other _____</p>
--	---

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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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.