REGISTRATION FORM

BIG BEAR
PHYSICAL THERAPY

PATIENT INFORMATION

NAME: _____
FIRST MI LAST

ADDRESS: _____
NUMBER/STREET APT. CITY STATE ZIP CODE

DATE OF BIRTH: _____ AGE: _____ GENDER: ☐ MALE ☐ FEMALE ☐ OTHER _____

SS#: _____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER _____

EMPLOYER: _____ OCCUPATION: _____ WORK #: _____

EMPLOYER ADDRESS: _____
NUMBER/STREET CITY STATE ZIP CODE

PREFERRED CONTACT: ☐ HOME _____ ☐ CELL _____ ☐ EMAIL _____

APPOINTMENT REMINDERS: ☐ TEXT ☐ VOICE CALL ☐ NONE

EMERGENCY CONTACT #: _____ NAME/RELATIONSHIP: _____

DOCTOR INFORMATION

REFERRING PHYSICIAN: _____

ADDRESS: _____
NUMBER/STREET CITY STATE ZIP CODE

PHONE NUMBER: _____ FAX NUMBER: _____

PRIMARY PHYSICIAN: _____ PHONE NUMBER: _____

Have you received Physical Therapy or Occupational Therapy treatment within the last 12 months? ☐ YES ☐ NO

Have you attended any Chiropractic, Speech Therapy or Home Care? ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

MEMBER ID #: GROUP ID #:

Is this the Patient's insurance? ☐ YES ☐ NO If NO, who is the policy holder:

POLICY HOLDER DOB: RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE COMPANY:

MEMBER ID #: GROUP ID #:

Is this the Patient's insurance? ☐ YES ☐ NO If NO, who is the policy holder:

POLICY HOLDER DOB: RELATIONSHIP TO PATIENT:

If you have a tertiary insurance please notify our office immediately

ACCIDENT INFORMATION

Auto (NF) or Workers Compensation (WC)

Is this work related? ☐ YES ☐ NO Auto accident? ☐ YES ☐ NO DATE OF ACCIDENT/INJURY:

WHICH STATE DID THE ACCIDENT OCCUR IN: Surgery? ☐ YES ☐ NO DATE OF SURGERY:

ATTORNEY INFORMATION:
NAME FIRM

ATTORNEY ADDRESS:
NUMBER/STREET CITY STATE ZIP CODE

NF/WC INSURANCE CARRIER:

CLAIM #: POLICY #:

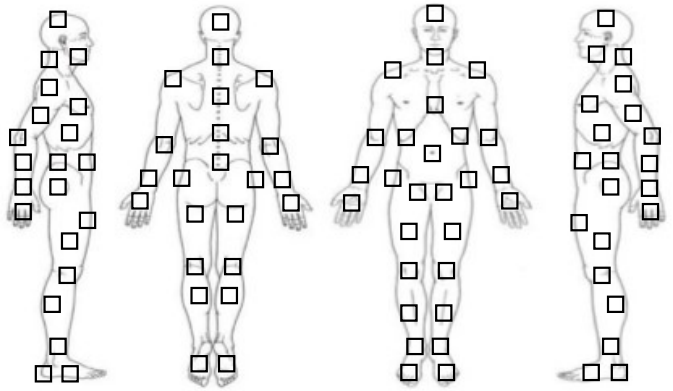
ADJUSTER NAME: PHONE NUMBER:

ADJUSTER EMAIL: FAX NUMBER:

Is your claim open? ☐ YES ☐ NO Is your adjuster aware you are starting therapy? ☐ YES ☐ NO

MEDICAL HISTORY

Please indicate where you have pain or other symptoms



None ⟶ *Unbearable*

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

HEIGHT: _____ WEIGHT: _____

MEDICATIONS:

Please list all over the counter and prescription medications you are currently taking. Include dosage & frequency.

_____

_____

_____

SURGICAL HISTORY:

List any surgical procedures you have had and the dates they were performed.

_____

_____

_____

DIAGNOSTIC TESTING:

Please check any diagnostic testing and/or treatments you have completed for this condition.

☐ MRI
☐ CT Scan
☐ Nerve Block
☐ Ultrasound
☐ X Ray
☐ Bone Scan
☐ Blood Tests
☐ Doppler Studies
☐ EMG
☐ Cardiac Stress Test
☐ Injections
☐ Urinalysis
☐ Other: _____

☐ Congenital Heart Defect
☐ Cancer
☐ Heart Problems/Heart Disease
☐ Joint Replacement/Repair
☐ Joint, Tendon or Muscular Pain
☐ Gastrointestinal Issues
☐ Osteoporosis
☐ Skin Problems
☐ Pacemaker
☐ Psychological
☐ High or Low Blood Pressure
☐ High or Low Blood Sugar
☐ Chest Pain/Angina/Palpitations
☐ High Cholesterol
☐ Abdominal Pain/Bloating/Gas
☐ Emphysema
☐ Shortness of Breath
☐ Poor Balance Recent Falls
☐ Coughing/Wheezing or Exertion
☐ Dizziness/Vertigo/Fainting/Blackouts
☐ Gout
☐ Severe Headaches
☐ Rheumatoid Arthritis
☐ Prostate Problems
☐ Anemia
☐ Epilepsy/Seizure Disorders
☐ Ulcers
☐ Circulation Problems/ Blood Clots
☐ Depression
☐ Liver Disease
☐ Kidney Disease
☐ Sexually Transmitted Disease/HIV/AIDS
☐ Tuberculosis
☐ Lung Disease
☐ Thyroid Problems
☐ Allergies
☐ Asthma/Bronchitis/Pneumonia/Chronic Cough
☐ Diabetes
☐ Stroke
☐ Chemical Dependency (Alcoholism)
☐ Latex Allergy
☐ Lyme Disease
☐ Hepatitis A, B, C
☐ Painful Bowels/Loose Stool/Constipation
☐ Multiple Sclerosis
☐ Depression/Anxiety/Panic Attacks

☐ Other: _____

Please provide details regarding the above checked conditions:

_____

_____

_____

_____

PATIENT FINANCIAL RESPONSIBILITY

APPLE CARE's focus is your overall health and wellness. As we continue to strive to help you meet these standards, it is important to us that you understand the terms "**Medically Necessary**", "**Clinically Appropriate**", "**Benefit Maximum Met**" and how this relates to your treatment.

"**Medically Necessary**" is defined as treatment or services that are specific to your diagnosis. When treatment is deemed medically necessary, your insurance company will reimburse **Big Bear PT** for services rendered according to physical therapy care that has a direct connection to document improved function based on our contractual agreement.

"**Clinically Appropriate**" or "**Benefit Maximum**": Insurance companies may deny care despite treatment that continues to manage, reduce or eliminate your pain. This may be "clinically appropriate" for your circumstances but may not be considered "medically necessary" by your insurance carrier. Benefit Maximum is defined as a specific number of physical therapy visits allowed by your insurance policy during a specific time frame. Most treatments reach a point where no further improvement can be expected. This is called the point of maximum therapeutic benefit (MTB). MTB can be reached when complaints either fully resolve, or when pain and/or disability persist – even with ongoing treatment.

"**Denials/Appeals**": It is a patient's responsibility to initiate an appeal with the insurance provider when services are denied.

Big Bear PT will provide the necessary clinical information upon request.

If your insurance company determines that services are no longer medically necessary, you will be billed $100.00 per visit for services that have been rendered.

I understand it is my responsibility to confirm my coverage with my insurance carrier and that **Big Bear PT** may verify such coverage as a courtesy to me. **Big Bear PT** will not be held responsible or liable for inaccurate information or denials provided by your insurance carrier after services have been rendered.

My signature below acknowledges that I have read and fully understand that:

1. **Big Bear PT** has discussed medical necessity limitations, clinically appropriate care, and specific number of office visits allowed per my insurance company.
2. I have been informed of my financial responsibility if my insurance company denies all or part of these services as not medically necessary.
3. I fully accept the financial responsibility to pay for denied services at the time my insurance carrier deems my treatment not medically necessary.
4. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier.

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

CONSENTS AND DISCLOSURES

(I) CONSENT TO RELEASE INFORMATION TO FAMILY OR FRIENDS

Ordinarily, discussion of medical records or billing information would not be disclosed to anyone but yourself over the phone. However, with your consent, our staff will speak with your significant other, close family member or other designated individual. Please understand that you are waiving your right to confidentiality if this consent is given.

_____ INITIAL HERE TO GIVE CONSENT

I am hereby giving my consent to **Big Bear PT** office staff to discuss my medical condition or billing concerns with the person/ persons I have designated below.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

(II) CONSENT TO RELEASE INFORMATION TO A TELEPHONE ANSWERING MACHINE

In an effort to protect your confidentiality, medical history and appointment reminder specifics (including date & time) will not be left on your answering machine, email and/or received in a text message; however, if you prefer us to do this, we can with your consent. Please understand that you are waiving your right of confidentiality if you give your permission.

_____ INITIAL HERE TO GIVE CONSENT

I am hereby giving my consent for the **Big Bear PT** office staff to leave medical history or appointment reminders (including date & time) on my telephone answering machine, email and/or text message.

_____ INITIAL HERE TO DECLINE CONSENT

(III) PATIENT AUTHORIZATION TO TREAT AND SUBMIT MEDICAL CLAIMS

I authorize payment to **Big Bear PT** for all physical therapy services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I consent to be assessed by and to receive treatment from **Big Bear PT** consistent with a plan of care. I confirm that I have been informed and have participated in planning the care and procedure(s) to be carried out by **Big Bear PT** and sign this consent willingly and voluntarily.

I consent to the release of information and/ or disclosure to **Big Bear PT** of all or any part of my medical record to other health care providers involved in my care or third-party payers as is necessary for processing claims.

I am aware my child is receiving Physical/Occupational Therapy at **Big Bear PT** I am unable to attend his/her office visits. Please accept this form as my consent to treat my child.

PARENT/ GUARDIAN INITIALS IF APPLICABLE: _____

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENTS AND DISCLOSURES.

PATIENT SIGNATURE: _____ DATE: _____

PARENTAL SIGNATURE FOR MINOR: _____ DATE: _____

ATTENTION

Big Bear PT NO SHOW/CANCELLATION POLICY

As a courtesy to other patients, as well as the Big Bear PT staff, we require notification to cancel and/or reschedule appointments at least 24 hours prior to your scheduled appointment. Please make sure to reschedule your appointment if you are canceling.

Missing or not showing to your scheduled appointment without proper advanced notification mentioned above, a fee of $35 will be collected upon your next visit. Should there be any misunderstandings or miscommunications regarding your scheduled appointment, please speak to one of us.

REFERRALS

PLEASE CHECK IF YOUR INSURANCE CARRIER REQUIRES A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN.

REFERRALS ARE PATIENT RESPONSIBILITY AND MUST BE COMPLETED AND TURNED IN TO **Big Bear PT** ON TIME TO AVOID ANY INSURANCE DENIALS.

VERIFICATION OF BENEFITS

Big Bear PT verifies patient benefits with your insurance carrier as a courtesy to the patient. Benefits quoted are not a guarantee of payment. Patient is ultimately responsible for any denied services rendered at **Big Bear PT**

WE THANK YOU IN ADVANCE FOR YOUR COOPERATION.

PATIENT BILL OF RIGHTS

Big Bear PT strives to ensure that each patient is provided the highest quality of care in accordance with high professional standards that are continually maintained and reviewed. We understand that patients have entrusted their care to us and we treat all patients with dignity, respect, and only provide appropriate services as needed. By requiring informed consent for treatment, we assure that each patient and/or his/her representative is involved in aspects of a treatment plan. Patients and their representatives are afforded consideration of their privacy concerning their own medical care program. Case discussion, consultation, examination and treatment are considered confidential and should be conducted discretely. The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. We will endeavor to involve patients in their treatment program by incorporating their feeling, interest, attitudes and goals in the treatment planning and implementation process. A patient has the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual preference or national origin.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE PATIENT BILL OF RIGHTS.

PATIENT SIGNATURE: _____ DATE: _____

PARENTAL SIGNATURE FOR MINOR: _____ DATE: _____

ATTENTION ALL PATIENTS

BIG BEAR
PHYSICAL THERAPY

Electrical Stimulation Pad Policy

Electrical stimulation therapy is a treatment modality that your referring physician or treating rehabilitation therapist may deem appropriate for the optimal treatment of your condition.

For sanitary reasons, company policy requires that all patients receiving electrical stimulation therapy be provided a personal set of electrical stimulation pads at a cost of Five ($5.00) Dollars per set ("Personal Pads")*. The Personal Pads will be utilized solely by the individual and will not be utilized by any other patient.

If electrical stimulation therapy is deemed appropriate for the optimal treatment of your condition, you will be required to pay Five ($5.00) Dollars per set of Personal Pads. The cost of Personal Pads must be paid prior to the receipt of electrical stimulation therapy and shall be the sole financial responsibility of the patient.

*Note – Patients covered by Workers' Compensation benefits shall not be responsible for payment of the Personal Pads.

Health Questionnaire Screening Form
for Coronavirus (COVID-19)

Please understand that the purpose of this Form is to elicit information to help promote the health and safety of all persons who may be involved in the meeting and/or showing, and that taking precautionary measures to prevent the spread of the Coronavirus (COVID-19) is paramount to those efforts.

Big Bear PT may cancel or postpone any appointment without prejudice or penalty upon any indication that a person who is attending the showing or meeting is exhibiting any symptoms of the Coronavirus (COVID-19) or any other cold or flu-like symptoms.

The person signing this Form hereby acknowledges and agrees that: (i) the information requested on this Form is being provided voluntarily, (ii) the information provided on this Form is confidential and is not intended for use outside of determining whether treatment can occur, (iii) the refusal or failure to answer each question below may result in the cancellation of any scheduled appointment, and that Big Bear PT reserves the absolute right, in their sole discretion, to refuse entry to that person; (iv) if the answer to questions 1-3 is "Yes" that person will not be permitted to receive treatment; (v) if the answer to question 4 is "Yes" and the answer to question 5 is "No" that person will not be permitted to receive treatment (vi) any person may be asked in the future to execute another Form in connection with a future appointment and (vii) they must notify Big Bear PT if they become symptomatic and/or test positive for COVID-19 within 48 hours of the last visit. Big Bear PT represents that they use and present this Form uniformly and in the same manner for all in-person interactions and meetings and in accordance with all Federal, State and Local Laws.

SCREENING QUESTIONS

Please answer the following 5 questions:

1. Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has had symptoms of COVID-19?
   ☐ YES ☐ NO
2. Have you tested positive for COVID-19 in the past 14 days?
   ☐ YES ☐ NO
3. Have you experienced any symptoms of COVID-19 in the past 14 days?
   ☐ YES ☐ NO
4. In the last 14 days, have you traveled from or been in close or proximate contact with someone who has traveled from another state or country for which New York State requires a mandated self-quarantine period?
   ☐ YES ☐ NO
5. If you answered "Yes" to question 4, have you completed the 14 day self-quarantine as currently required by New York State?
   ☐ YES ☐ NO

Print Name	Signature	Date

Important Note: This Form should not be construed as offering or providing legal advice in any form. This Form is not intended to replace the reader's need to speak with their own legal counsel regarding the issues presented. All readers should seek independent legal advice prior to instituting any re-entry policies and/or practices.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, acknowledge
(insert name of patient)

receipt of a copy of Provider's **NOTICE OF PRIVACY PRACTICES**.

Date: _____

Patient or Legal Guardian Signature:_____

Legal Guardian Name:_____

Received by:

_____
(Print Name of Staff Member)

_____
(Signature of Staff Member)

*****This completed form must be scanned into the patient's EMR*****

62 Benton Hollow Road
Liberty, NY 12754
Office Phone: (845) 750-9744
Email: bigbearphysicaltherapy@gmail.com

Notice of Privacy Practices

Effective Date: October 2018

This Notice provides an overview of the privacy practices of Big Bear PT (also referred to in this Notice as "we," "us," and/or "our"). The privacy practices described in this Notice will be followed by all Big Bear PT healthcare professionals, employees, staff, trainees, students, volunteers, and business associates. If you have any questions about this Notice, please contact our Privacy Officer.

This Notice describes how protected health information (defined below) about you may be used and disclosed and how you can get access to this protected health information. This Notice is not a complete listing of how we use and disclose your protected health information. This Notice applies to all protected health information held in any form by the Big Bear PT entities listed at the end of this Notice. **Please review this Notice carefully.**

Protected health information (also referred to in this Notice as "medical record," "health information," and/or "information") is your individually identifiable information, whether in electronic, paper, or oral form, which may include, but is not limited to, your geographic information, your demographic information, information on healthcare services you have received or may receive in the future, your healthcare insurance benefits, full-face photographs and any comparable images of you, and any unique numbers that may identify you.

Your Information. Your Rights. Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communications
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy Notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

▸ See page 2 for details on these rights and how to exercise them.

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information
- Raise funds

▸ See page 3 for details on these choices and how to exercise them.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

▸ See pages 3 and 4 for details on these uses and discolures.

Your Rights	**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.
Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. To request a copy of your medical record, please contact our Medical Records Department. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete by submitting the request in writing to the Privacy Officer, along with proper documentation to support the request. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for 6 years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy Notice	• You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting our Privacy Officer. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/** • We will not retaliate against you for filing a complaint.

Your Choices	**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, please contact our Privacy Officer regarding your preference, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures	**How do we typically use or share your health information?** We typically use or share your health information in the following ways.
Treat you	• We can use your health information and share it with other professionals who are treating you without your consent. ***Example:*** *The physical therapist treating you for an injury shares your treatment notes with your physician.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary without your consent. ***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities without your consent. ***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

Help with public health and safety issues	• We can share health information about you for certain situations such as: — Preventing disease — Helping with product recalls — Reporting adverse reactions to medications — Reporting suspected abuse, neglect, or domestic violence — Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.

Continued from page 3.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: — For workers' compensation claims — For law enforcement purposes or with a law enforcement official — With health oversight agencies for activities authorized by law — For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and provide you a copy of this Notice.
- We will not use or share your information other than as described in this Notice unless you tell us we can in writing by completing and signing our HIPAA Authorization Form. If you tell us we can use or share your information other than as described in this Notice, you may change your mind at any time by informing our Privacy Officer of the change in writing.

Note on Incidental Disclosures
Despite our implementation of reasonable and appropriate safeguards to protect the privacy of your protected health information, your protected health information may be incidentally disclosed in connection with otherwise permissible or required uses or disclosures of your information. For example, other patients in the treatment area may observe and/or overhear discussions regarding your protected health information during the course of your treatment session. The HIPAA Privacy Rule permits such incidental disclosures of your protected health information.

Changes to the Terms of this Notice
We can change the terms of this Notice without first notifying you, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

This Notice of Privacy Practices applies to Big Bear PT., and all their affiliated entities that provide outpatient rehabilitation services in New York.

For more information regarding the Notice of Privacy Practices, please see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/Noticepp.html

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