

BCM Innovative Therapies, INC.

Patient Information

Patient Name: _____

Insurance#: _____

Patient Name: _____ DOB: ____ / ____ / ____ Age: _____ Sex: M F

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Social Security Number: ____ / ____ / ____ Dominant Language: English Spanish _____

Patient Information:

Employer: _____ Phone: _____

Address: _____ City: _____ ST: _____ Zip: _____

Single Married Widowed Divorced Separated

Emergency Information:

Emergency Contact: _____ Relationship: _____

Phone Number: _____ Address: _____

Physician Information

Referring Physician: _____ Primary Physician: _____

Referring MD's Phone: _____ Primary MD's Phone: _____

Referring MD's Fax: _____ Primary MD's Fax: _____

Insurance Information

Primary Insurance: _____ Policy Number: _____

Group: _____ Phone: _____ Address: _____

Name of Insured: _____ Relation to Patient: Parent Self Spouse

Secondary Insurance: _____ Policy Number: _____

Group: _____ Phone: _____ Address: _____

Name of Insured: _____ Relation to Patient: Parent Self Spouse

Patient Release and Insurance Authorization: *(Initials are required for release of Medical Information and Authorization of Payment)*

____ I hereby authorize payment directly to the Center for the benefits due to me in my pending claim and/or Major Medical Benefits otherwise payable to me, but not to exceed the physician's and/or the Institutes regular charges for therapy for this treatment period.

____ I further authorize the release of any medical information required by my insurance carrier(s) and/or treating physicians

Notice: Misrepresentation and/or falsification of essential information requested in this document may be subject to monetary fines and/or imprisonment, if convicted, under federal law.

My signature Indicates that I have read and understood the packet provided upon my admission to the Center. This packet includes a consent form, insurance and medical release form, and insurance benefits assignment/financial agreement.

Signature of Patient

Date

Facility Representative

Date

Patient Name: _____

Insurance #: _____

BCM INNOVATIVE THERAPIES, INC.

Billing Policy

The following sets forth the general billing policy of **BCM Innovative Therapies**. Please review this information and sign where indicated.

- 🐝 I understand that it is my responsibility to provide the office of **BCM Innovative Therapies** with current, accurate billing information at the time of check in and to notify them of any changes in this information.
- 🐝 I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- 🐝 I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, credit card, money order, or cashier's check.
- 🐝 I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any treatment that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my treatment. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated visits to be performed and 2) current information provided to clinic by my insurance carrier.
- 🐝 I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- 🐝 I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- 🐝 My signature below confirms that I have read these billing policies and my financial obligation as pertains to the provider's of BCM Innovative Therapies.

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

Patient Name: _____

Insurance#: _____

BCM INNOVATIVE THERAPIES, INC.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, **BCM INNOVATIVE THERAPIES, INC.** creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation they will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting, or arranging for medical review, legal services, and auditing functions, etc.) and the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have had the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations, be restricted. I also understand that the Practice and I must agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

Patient Name: _____

Insurance#: _____

Statement of Patient Bill of Rights

In recognition of the responsibility of this facility in the rendering of patient care, these rights are affirmed in the policies and procedures of

BCM INNOVATIVE THERAPIES, INC.

Service(s) without regard to race, color, age, sex, sexual orientation, religion, marital status, handicap, national origin or sponsor:
The patient's cultural, psychological, spiritual & personal values are respected.

- Reasonable physical access to the Facility
- Privacy appropriate to care
- Considerate, respectful and dignified care
- A secure environment for self and property
- The opportunity to communicate effectively

Uncompromised care regardless of the presentation of complaints relating to the quality of previous care received in this Facility.

Strict confidential treatment of disclosures and records and to opportunity to approve or refuse the release of such information, except when required by law

The opportunity to obtain complete and current information from the patient's therapist concerning the diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on the patient's behalf. To know, by name the doctor responsible for coordinating the patient's care.

The opportunity to participate in decisions involving the patient's health care, unless contraindicated by concerns for the patient's health.

Information necessary from the patient's doctor to give an informed consent prior to the start of any procedure and/or treatment including:

- Significant medical risks involved
- Probable duration of incapacitation
- Information and alternatives for medical care or treatment
- Consequences of not complying with therapy
- Name of person responsible for procedures and/or treatment

Opportunity to refuse treatment to the extent permitted by law and information regarding the medical consequences of refusal or noncompliance with prescribed therapy

Patients have the right to expect a quick response to reports of pain.

Your reports of pain will be believed;

- Information about pain and pain relief measures;
- A concerned staff committed to pain prevention and management;
- Health professionals who respond quickly to reports of pain; and
- Effective pain management

By signature herein, I certify that I have received this notice with company Administrator or their designee.

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

Patient Name: _____

Insurance #: _____

BCM Innovative Therapies, Inc.

Admission Form

Comprehensive Treatment Plan Agreement

The following is a description of this clinic's policies regarding the comprehensive treatment plan. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies please ask a representative of this clinic before signing.

Non Discrimination Policy

The Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information contact the Front Office Supervisor or TTY State Relay at 1 800 735-2988.

Speech, Hearing and Visual assistance communication guides are available at no charge and upon request. For further information contact the Front Office Supervisor or TTY State Relay at 1 800 735-2988.

Initials _____

Scheduling Policy and Consent to Treat

I, the Patient/Parent or Legal Guardian hereby consent to treatment for therapy services. I further understand that once a weekly treatment appointment schedule has been determined, this clinic is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, I must give as much advanced notice as possible for the clinic to attempt to accommodate this request. A change in time may necessitate a change in therapists as well.

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur each week. I understand that I have up to two weeks from the time of cancellation to make up for the cancelled session. I understand that I will lose the cancelled session if not made-up within two weeks. I understand that a makeup session may occur with this clinic's substitute therapist, our regular therapist, or another skilled therapist with this clinic and may be offered as a separate session or by adding on additional time to several sessions.

I understand that notification of vacations or family obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling our appointment(s). I understand that we are entitled to make up sessions for vacation time two weeks before or following our vacation time.

I understand that the clinic is open except in cases of severe weather conditions requiring businesses to close. It is my responsibility to call the clinic to determine whether changes in the scheduled time of treatment are needed and if the opening of the clinic has been delayed. Families may cancel treatment if they do not wish to travel in poor weather conditions. I understand that if treatment time falls on a federal holiday that I am encouraged to make up these sessions.

I understand that if our therapist is ill or on vacation, the clinic will provide a substitute therapist to ensure continuation of services. This clinic will make every effort to schedule the therapist at our regularly scheduled appointment time. If this cannot occur, the clinic will provide an alternate appointment time.

I understand that if we do not keep a scheduled appointment or if we do not cancel a session before the session is scheduled to begin, that time of treatment is forfeited.

I have read and agree to abide by the above policies.

Initials _____

BCM Innovative Therapies, Inc.

Admission Form Comprehensive Treatment Plan Agreement

Patient Name: _____

Insurance #: _____

Office Policy for Families with Child Patients

All individuals are asked to please wait in the waiting room during treatment sessions. Observations of my treatment session may be scheduled upon request.

I understand that I am responsible for waiting with my child in the waiting room until the treatment session begins and monitoring my child's play in the waiting room. I understand that the clinic prefers I wait during the session so that I am able to monitor some of my child's treatment when appropriate. I understand that it is the policy of this clinic that a parent or legal guardian must remain in the clinic during treatment sessions.

Initials _____

Acknowledgement of Risk

I understand that there is some risk inherent in the use of therapeutic equipment at this clinic, and I agree to indemnify and hold the clinic harmless for any and all losses and claims for any injuries occurring to myself from the use of therapeutic equipment.

Initials _____

Coordination of Care

I give permission to have this clinic contact and discuss my case with all persons whose names I have provided as professionals working with me.

Initials _____

I give permission for this clinic to send copies of progress reports to all referral sources whose names I have provided.

Initials _____

Teaching and Education of Students

I give permission for occupational, physical, speech therapy and nursing students to observe my therapy. I understand that I will be notified before such observation takes place.

Initials _____

Consent to Photograph

I give permission for photographs/videotapes to be taken of myself, for educational and/or promotional purposes.

Yes I give my permission No I do not give my permission

Initials _____

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

Patient Name: _____

Insurance#: _____

BCM INNOVATIVE THERAPIES, INC. Arbitration Agreement

In consideration of BCM Innovative Therapies, Inc. agreeing to treat me as a patient, I hereby agree that any controversy between us of whatsoever nature will, on the written request of either of us served on the other, be submitted to arbitration. The arbitration proceeding will comply with and be governed by the provisions of the Texas General Arbitration Act, Chapter 171 of the Texas Civil Practice and Remedies Code. Should Arbitration be revoked by either of us, then each one of us will appoint one person as an arbitrator to hear and determine the dispute. If they are unable to agree, then the two chosen arbitrators will select a third impartial arbitrator whose decision will be final and conclusive on us, the parties to this Agreement. The expense of arbitration proceedings conducted pursuant to this Agreement will be allocated between us as decided by the arbitrators.

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

Acuerdo De Arbitraje

En consideración y concordancia con BCM Innovative Therapies, Inc. para tratarme como un paciente, yo por medio de la presente estoy de acuerdo que cualquier tipo de controversia entre nosotros que ocurra en el period de servicio requerido, será sometida a arbitraje. El procedimiento de arbitraje será conformado y será regido conforme a lo establecido en el Acta de Arbitraje General de Texas Capitulo 171 de Código de Practicas Civiles y Remedios de Texas. El Arbitraje podrá ser solicitado por cualquiera de las dos parties, entonces cada una de las dos partes designara a un Árbitro para oír y solucionar la disputa. Si losdos árbitros escogidos no se pusieran de acuerdo, entones ellos dos podrán nombrar un tercer arbitro que sea imparcial cuya decisión será final y concluyenta par alas dos pertes en la disputa. Los gastos del Arbitraje serán divididos entre las dos partes y según como lo decidan los Árbitros.

Firma del Paciente/Padre/Guardia

Fecha

Firma del Representante de Instalación

Fecha

Patient Name: _____

Insurance#: _____

BCM INNOVATIVE THERAPIES, INC.
Pet Introduction Program Consent Form
Agreement to Participate

Please Read This Carefully. You Will Be Asked To Sign It.

Benefits: I am voluntarily allowing my child to participate in a Pet Introduction Program being sponsored by BCM Innovative Therapies.

I understand that this type of program has been instituted in other Patient care settings and that studies have shown that pets can have a beneficial effect on health and well-being – providing companionship, love, increased physical activity and emotional responsiveness.

Risks: I am aware and have been informed of the fact that live, domestic animals will be provided by volunteers to be used in the Pet Introduction Program. I understand that the behavior and reactions of the animals are not entirely predictable, and therefore, the animal providers cannot guarantee that the animal will behave properly or that the animal will not bite, claw, scratch or otherwise inflict injury. I, also, am aware of no allergy, skin or respiratory sensitivity or other medical condition that my child has which might make toughing, handling or being in close proximity to dogs, cats or other domestic animals used in the program, potentially harmful to my child's health.

Agreement: I have been assured that the volunteers providing the animals have carefully selected them and that the animals to be used have never shown any vicious tendencies heretofore. I have been reassured that the activities in the Pet Introduction Program will be supervised at all times by staff and volunteers of BCM Innovative Therapies. I agree I will encourage my child to handle the animals gently. I understand that my child would be provided, within the capabilities of BCM Innovative Therapies, medical assistance for any physical injury that may result from my child's participation in this program. I agree to assume the risk of any injury or illness resulting from my child's participation and agree to hold BCM Innovative Therapies and the staff harmless for the actions of the animals used in this program.

___ Yes, I want to participate in the Pet Introduction Program.

___ No, I do not want to participate in the Pet Introduction Program.

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

Patient Name: _____

Insurance#: _____

BCM INNOVATIVE THERAPIES, INC. **Patient Responsibilities**

Purpose: To inform the patients/parents/guardian of their responsibilities as a participant in the total care process.

Policy: All Patients are responsible for:

1. Behavior that shows respect and consideration for other patients, family, visitors and personnel of the clinic.
2. Assuring that the financial obligations for health care rendered are paid in a timely manner.
3. Accepting consequences of their actions if they should refuse a treatment of procedure, or if they do not follow or understand the instructions given them by the doctor or their health care team member.
4. Providing the clinic to the best of their knowledge with an accurate and complete medical history about present complaints, past illnesses, hospitalization, surgeries, and existence of advance directives, medications and other pertinent data.
5. Following the plan of treatment recommended by the doctor primarily responsible for the patient's care and /or other personnel authorized by the clinic to so instruct patients.
6. Notifying the clinic of ANY change in their condition or circumstances, including change of insurance coverage.
7. Keeping their appointment for scheduled services. If they anticipate a delay or must cancel the scheduled service, it is their responsibility to notify the clinic as soon as possible.
8. The disposition of their valuables while at the clinic is the responsibility of the patients or guardian.

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

Patient Name: _____

Insurance#: _____

BCM Innovative Therapies, Inc. Patient Cancellation Policy

Purpose:

To inform the Patient and parents of cancellation policy and clinic closing

Cancellation Policy:

Patients are responsible for cancelling scheduled appointment 24 hours in advanced. **Three cancellations in a month could result in Patient losing therapy appointment time due to clinic’s waiting list.**

Notification of vacations or family obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling our appointment(s).

The clinic will post any Holiday closing 1 week prior to date. And Clinic will be closed during Spring break that coincides with Corsicana I. S.D. These dates will be posted in the waiting room of the facility. If you would like for your child to be seen during this time we will be glad to discuss this with you.

_____ I have read and agree to abide by the above policies.

Sick Policy Consent

It is the policy of the Center that in the event the patient becomes ill, the Center will utilize the following guidelines for re-admitting patients into treatments as listed below.

Cancel appointment if one or more of these conditions are present:

- Oral temperature of 100 degrees or above
- Vomiting, nausea or severe abdominal pain
- Marked drowsiness or malaise
- Sore throat, acute cold, or persistent cough
- Red, inflamed, or discharging eyes
- Acute skin rashes or eruptions
- Swollen glands around jaws, ears & neck
- Suspected scabies or impetigo
- Any skin lesion in the weeping stage
- Earache
- Pediculosis (head lice)
- Diarrhea: runny, watery or bloody
- Other symptoms suggestive of acute illness

Return to Therapy Guidelines

- Fever free for 24 hours
- Symptom free of vomiting, nausea or severe abdominal pain
- Symptom free of marked drowsiness or malaise
- Symptom free of sore throat, acute cold, or persistent cough
- Treated pediculosis (head lice)
- Symptom free Diarrhea: runny, watery or bloody
- All health conditions listed above have been treated and resolved

I agree to reschedule my appointment or my child’s appointment after the illness has been treated and resolved.

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

Patient Name: _____

Insurance#: _____

BCM INNOVATIVE THERAPIES, INC.

Advance Directives Policy

BCM Innovative Therapies, Inc. requires each person receiving treatment in this facility to sign the following notice to be in compliance with the Self-Determination Act regarding advance directives. In this facility should a patient suffer a life-threatening situation this signed notice implies agreement on the resuscitation and transfer of the individual to a higher medical care. Therefore any previous signed advance directives, including durable power of attorney will not be observed in this facility. Concerns regarding this policy need to be addressed with your therapist.

I have read the above policy and understand the information in this policy.

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ DOB: _____ Insurance ID#: _____

Does the patient suffer from allergies? No Yes If yes, please explain _____

Does the patient suffer from diabetes? No Yes If yes, please explain _____

Medications: No Yes (See Current Medication List)

History of seizure disorder: No Yes If yes, please explain _____

Medications: No Yes (See Current Medication List)

History of Gastrointestinal problems : No Yes Reflux Colic Digestive Problems Failure to Thrive

Medications: No Yes (See Current Medication List)

History of heart problems: No Yes If yes, please explain _____

Medications: No Yes (See Current Medication List)

History of respiratory disorders: No Yes: RSV Bronchopulmonary Dysphasia Pneumonia Asthma
 Chronic Respiratory Sinus Infection

Medications: No Yes (See Current Medication List)

Is the patient currently taking Antibiotics: No Yes: (See Current Medication List) ** If yes, fill out Infection Control Form.

Family history of developmental problems or genetic disorders:

Yes: Which: _____ Family Member: _____

No (Examples: Learning difficulties, Attention Deficit Disorder, Psychological Problems, Behavior Disorders, Cerebral Palsy)

Previous therapy services in the past?

Yes: When: _____ Where: _____ No

Vision Problems: No Yes If yes, explain: _____

Glasses: No Yes If yes, explain: _____

Auditory: Localizes to sound: No Yes Has hearing been checked: No Yes, When: _____
Results: _____

History of Ear Infections: No Yes How many per year: _____

History of Hearing Problems: No Yes If yes, explain: _____

Currently taking Medications: No Yes See Current Medication List

Other Specialists:

Physician Psychologist Psychiatrist Geneticist Neurologist Cardiologist
Audiologist ENT Specialist Other: _____

Name of Specialist if applicable _____

BCM Innovative Therapies MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ DOB: _____ Insurance ID#: _____

Occupational Therapy Questions/Information:

Are there any eating concerns (picky eater, avoidance of food textures or tastes, drooling, poor control of food in mouth)?

Dressing: (Yes, no, needs help)

Removes: Shoes _____ shirt/jacket _____ pants _____ underpants _____

Puts on: Shoes _____ shirt/jacket _____ pants _____ underpants _____

Describe any help needed: _____

Any Additional Concerns:

Education:

Current school placement: _____

Grade or class: _____

Work

Place of Employment: _____

Patient Signature

Date

Therapist (OT)

Date of IE

Therapist (ST)

Date of IE

Therapist (PT)

Date of IE



PatientName: _____
Insurance#: _____

BCM Innovative Therapies, Inc.
Clinical Records Release/Request Form

(Check One)

- Release**- Releasing information from us to you or your provider
- Request**- Requesting information from another provider to us

Date: ____/____/____

Name: _____ Date of Birth: ____/____/____

Address: _____

City/State/Zip: _____

Phone: _____ Social Security #: ____-____-____

I authorize BCM Innovative Therapies, Inc. to release / request (circle one) the following information:

Information: Requested / Released (circle one):

To/From (circle one): _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

- I understand that this authorization shall be valid through ____/____/____ (1 Year Expiration) but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information released.
- I understand that if I refuse to consent the disclosure of information, the agency may be unable to serve me and/or be able to provide the most appropriate care for me/my child.
- I understand that the release of information may not be re-released to any other person or organization without my written consent.

Patient or Parent (if minor): _____ Date: ____/____/____

Witness by: _____ Date: ____/____/____



Patient Name: _____
Insurance#: _____

As a courtesy to our patients, we would like to give you appointment reminders. Please let us know how you would like to be contacted. Thank you.

I give BCM Innovative Therapies, Inc. consent to contact me using:

- Phone# _____
- E-mail Address _____
- Do Not Contact

Signature of Patient/Parent or Legal Guardian

Date

Facility Representative

Date

