BCM Innovative Therapies, INC.

Patient Information

Client Name:Last:_____**M:**____**First:**_____ **Preferred to be called:**_____

DOB:MM/DD/YYYY _____/_____/_____ **Age:**_____ **Sex: M F**

Parent/Guardian Name:_____ **Relationship to the Client:**_____

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

Phone:_____ **Social Security Number:**_____/_____/_____ **Dominant Language:** ☐**English** ☐**Spanish** ☐

_____**Parent/Guardian Information:**

Employer:_____ **City:**_____ **ST:**____ **Phone:**_____

Emergency Contact:_____ **Relationship:**_____

Address:_____**City:**_____ **ST:**____ **Zip:**_____

Phone:_____

Physician Information

Referring Physician: _____ **Primary Physician:**_____

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

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

DATE OF MOST RECENT DR. VISIT: _____

Insurance Information

Primary Insurance:_____ **Policy Number:** _____

Group:_____ **Phone:**_____ **Address:**_____

Name of Insured:_____ **DOB:**_____ **Relation to Patient:** ☐**Parent** ☐ **Self** ☐ **Spouse**

Do you have a secondary Insurance: Y N

Secondary Insurance: _____ **Policy Number:**_____

Group:_____ **Phone:**_____ **Address:**_____

Name of Insured:_____ **DOB:**_____ **Relation to Patient:** ☐**Parent** ☐ **Self** ☐ **Spouse**

Patient Release and Insurance Authorization:
Initials are required below 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

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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/ Parent or Legal Guardian **Date**

_____ _____

Facility Representative **Date**

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

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

BCM INNOVATIVE THERAPIES, INC.

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

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

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 clinics 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 understand that a fully qualified and supervised COTA/SLP-Assistant or Level ll Student, Tech may treat me or my child.

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

Office Policy for Families with Child Patients

I understand that infants and toddlers often need to be accompanied by a parent during treatment; all other individuals are asked to please wait in the waiting room during treatment sessions. Observations of my child's 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 my child or myself from the use of therapeutic equipment.

*Initials*_____

Coordination of Care

I give permission to have this clinic contact and discuss my child's/my case with all persons whose names I have provided as professionals working with my child or myself.

*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 child's 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, or my child for educational and/or promotional purposes.

___Yes I give my permission ___No I do not give my permission *Initials*_____

Complaint Resolution Procedures

Here at BCM Innovative Therapies, our goal is to serve you and your family to the best of our abilities. If you have a complaint about our facility or one of our employees, please follow the guidelines below to help us resolve the issue in a timely manner.

- If you have a complaint about an issue involving the facility/environment, such as the waiting room or the restroom, please see our receptionist.
- If you have a question or complaint involving your insurance or billing, please see our office manager or our assistant office manager, Anna Stroder or Sember Stroder.
- If you have a complaint involving your treating therapist/therapy, please direct your compliant/question to Faye Hightower, SLP for speech therapy, or Betsy Stroder, OTR for occupational therapy.
- If you feel your complaint is not resolved to your satisfaction, please see our Administrator Betsy Stroder, OTR, or our Alternate Administrator Anna Stroder, CFO.

Our phone number is 903-874-6315 if you would like to call with your complaint. If the person you need to speak with is unavailable, they will return your call as soon as possible.

I agree to follow these procedures about any complaints I have with BCM Innovative Therapies, Inc. and understand that they will do all they can to resolve my complaint in order to better serve me or my child.

*Initials*_____

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.

*Initials*_____

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Acuerdo De Arbitraje

En consideración y concordancia con BCM Innovative Therapies, Inc. para tratarme como un(a) paciente, yo estoy de acuerdo que cualquier tipo de controversia entre nosotros que ocurra en el periodo de servicio requerido, será sometida a un arbitraje. El procedimiento de el 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 partes, entonces cada una de las dos partes designara a un árbitro para oír y solucionar la disputa. Si los dos árbitros escogidos no se pusieran de acuerdo, entones ellos dos podrán nombrar un tercer árbitro que sea imparcial cuya decisión será final y concluyenta para las dos partes en la disputa. Los gastos del Arbitraje serán divididos entre las dos partes según como lo decidan los Árbitros.

*Initials*_____

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.

*Initials*_____

Patient Cancellation Policy

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

Cancellation Policy:

Patients are responsible for cancelling scheduled appointments 24 hours in advance. **Three (3) cancellations of scheduled appointments will result in Patient being discharged from this facility. A patient that has been discharged may not resume therapy unless there is a change in medical status or until 6 months have passed from the previous evaluation/re-evaluation. Any re-scheduled appointment will not count as a cancellation**

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. *Initials*_____

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.

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. If in the event the person has an Advance Directive and has provided it to our office, we will honor the patient's directive. Any further concerns regarding this policy should be addressed with your therapist.

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

*Initials*_____

211 EMERGENCY DISASTER PROGRAM ASSISTANCE

Please indicate who will be registering the clinic with 2-1-1 Emergency Disaster Services provided through the Texas Department of State Health Services

- ○ Patient/Parent/Guardian
- ○ Family Member/Power of Attorney
- ○ Facility Representative
- ○ I decline to register the patient for 211 services
- ○ Other:_____

ACKNOWLEDGEMENT OF RECEIPT OF POLICIES

1. Notice of Privacy Practices
2. Statement of Patient Bill of Rights
3. Sick Policy Consent
4. Patient Responsibilities
5. Advance Directive Policy
6. Advance Directive and Do Not Resuscitate Orders
7. State of Texas Emergency Assistance Registry (STEAR)

I acknowledge that BCM Innovative Therapies, Inc. provided me with a written copy of the above policies and was afforded the opportunity to read and ask questions.

_____ _____

Signature of patient/parent or legal guardian Date

_____ _____

Signature of facility witness Date

BCM INNOVATIVE THERAPIES, INC.

Medical History Questionnaire

What is the date of the patient's most recent appointment with their physician?_____
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 of 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? ☐ No: ☐Yes: When:_____ Where:_____

Birth History: ☐ Full Term Pregnancy ☐ Partial Term: _____Weeks Gestation ☐ Natural Birth ☐ C-Section
Complications:_____

Complications following Birth: ☐ Feeding Difficulties ☐ Jaundice ☐ Respiratory Difficulties ☐ Congenital Defects

Developmental History: Hospitalizations Since Birth: ☐ No ☐
Yes:_____For:_____

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: _____

Does the child have PE Tubes? ☐ No ☐ Yes If yes, please explain:_____

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

_____
_____

BCM INNOVATIVE THERAPIES, INC.
Medical History Questionnaire (2)

Other Specialists:

☐ Physician ☐ Psychologist ☐ Psychiatrist ☐ Geneticist ☐ Neurologist ☐ Cardiologist
☐ Audiologist ☐ ENT Specialist ☐ Other:_____
Name of Specialist if applicable:_____

Therapy Questions/Information:

At what age (in months) did your child:
____Sat up unassisted
____Crawled:

How did they crawl? On Tummy__ Creep on hands and knees__ Scooted on one leg__ Did not crawl__

___pull to stand ____Stood ___Walked

____Babbled ___Said first word ___Combined words
____Toilet Trained

Parent Concerns:

Does he/she seem overly sensitive to (check all that apply):

☐ Being Touched ☐ Being hugged ☐ Having face washed or hair cut

☐ Eating certain foods, flavors or textures:
list_____

☐ Wearing certain clothes:
list_____

☐ Does he/she avoid touching things or getting dirty?_____

☐ Covers ears or hides head around certain noises?_____

☐ Which hand is used more often? ☐ right ☐ left ☐ equal

Self Help: (please check any of the following your child CAN do)

☐ suck from a bottle/straw
☐ drink from a cup held for him/her
☐ hold and drink from a cup with sipper top ☐ without a top
☐ finger feed
☐ feed self without help
☐ hold a spoon
☐ scoop with a spoon
☐ use a fork
☐ use a knife to spread ☐ use a knife to cut
☐ Eats with much spilling ☐ little spilling ☐ no spilling

BCM INNOVATIVE THERAPIES, INC.
Medical History Questionnaire (3)

Dressing: (yes , no, needs help)

Removes: Shoes_____ shirt/jacket_____ pants_____ underpants_____

Puts on: Shoes_____ shirt/jacket_____ pants_____ underpants_____

Describe any help needed: _____

Is your child toilet trained? ☐ No ☐ Yes

Psychological and Play:

Does your child have difficulties:
Paying attention: ☐ No ☐ Yes
Sticking to one activity for 2-3minutes: ☐ No ☐ Yes for 15-20mins: ☐ No ☐ Yes

Does your child:

Have difficulty switching activities: ☐ No ☐ Yes

Have rituals or need to do things the same way each time: ☐ No ☐ Yes

Become frustrated easily: ☐ No ☐ Yes

Have tantrums: ☐ No ☐ Yes Hit/bite: ☐ No ☐ Yes

Describe any other behavior problems you have with your child:_____

Does your child have many friends: ☐ No ☐ Yes

Does he/she prefer to play with older children: ☐ No ☐ Yes Younger children: ☐ No ☐ Yes Alone: ☐ No ☐ Yes

What are your child's favorite play activities toys, games etc.? _____
_____
_____

Does your child have unusual fears? ☐ No ☐ Yes

Please check any terms that apply to your child:

☐ Shy ☐ friendly ☐ nervous ☐ cooperative ☐ creative ☐ thumb sucker ☐ jealous ☐ nail biter ☐ destructive

☐ angry ☐ aggressive ☐ bites ☐ fidgety ☐ daydreams ☐ ritualistic ☐ rocks ☐ head banger

☐ poor tolerance for change ☐ avoids eye contact ☐ affectionate ☐ short attention span ☐ lazy ☐ overly active

☐ absent minded ☐ cuddler ☐ Picky eater ☐ poor appetite ☐ rarely shows emotions

Other:_____

BCM INNOVATIVE THERAPIES, INC.

Medical History Questionnaire (4)

Any Additional Concerns:

_____
_____
_____
_____
_____

Education:

Current school : _____

Grade or class:_____

Does your child receive any school based therapy: ____yes ____ no

If yes date when started:_____ stopped:_____

Does your child receive any form of special education?

_____

Describe any problems your child has had at school:

_____
_____
_____
_____

_____ _____
Signature of Patient/Parent or Legal Guardian Date

_____ _____
Therapist (OT) Date of IE

_____ _____
Therapist (ST) Date of IE

_____ _____
Therapist (PT) Date of IE

BCM INNOVATIVE THERAPIES, INC.
PATIENT CONTINUITY OF CARE AND RISK CLASSIFICATION FORM

Allergies:

☐ No Known Drug Allergies (NKDA)

☐ DRUG ALLERGIES:_____

Food allergies: ☐ No ☐ Yes If yes, please list:_____

☐

Other:_____

Date	Medication	Dosage/Frequency	Route of Administration

PATIENT'S BLOOD TYPE: (CIRCLE PATIENT'S BLOOD TYPE)

A + A- B+ B- AB+ AB- O+ O- NOT KNOWN

ADVANCE DIRECTIVE PREFERENCE: (CHECK ONE ANSWER)

____ **The patient does not have an advance directive preference**

____ **The patient does have an advance directive preference (Provide copy to clinic)**

Emergency Contacts:

NAME **PHONE:** **RELATIONSHIP TO PATIENT:**

1._____

2._____

3._____

To be completed by clinical personnel: During the disaster situations, therapy may be postponed for up to 8 hrs. -level 1: postponed for 9-48 hrs. level2: postponed for 49-71 hrs. level 3: postponed for 72-96+ hrs. level4.

EMERGENCY CLASSIFICATION: (circle level) 1 2 3 4

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED:_____

DATE OF BIRTH: Month:_____ Day:_____Year:_____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

PHONE (_____)_____ Alt. PHONE: (____)_____

EMAIL ADDRESS (optional): _____

AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION: WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: BCM Innovative Therapies, Inc.
Address: 3728 S Highway 287
City: Corsicana State:Texas Zip Code: 75109

Phone: 903-874-6315 FAX: 903-874-6387

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name :_____ Relationship:_____

Address: _____

City _____ State _____ Zip Code _____

Phone _____ FAX _____

REASON FOR DISCLOSURE:
(choose option(s) that apply below)

- Treatment/continuing medical care
- Personal use
- Billing or claims
- Insurance Legal purposes
- Disability determination
- School
- Employment
- Other:_____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- **All health information**
- **EVAL**
- **Re-Eval**
- **Physician's Orders**
- **Progress Notes**
- **Discharge Summary**
- **Billing Information**
- **Other**

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Test Results)

_____Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month:_____Day:_____ Year:_____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **Date**

Printed name of legally authorized representative (if applicable): _____
If representative, specify relationship to the individual: ¨ Parent of minor ¨ Guardian ¨ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____

BCM INNOVATIVE Therapies, Inc.

Discovering possibilities.

Exclusive Therapy Form

To the best of my knowledge, _____ (**Patient Name**) is not currently receiving any ____ OT____ PT____ ST therapy at any other Facility/Home Health provider as of _____ (**Evaluation Date**).

OR CHANGE IN PROVIDER REQUEST

_____ (**Patient Name**) was receiving ____OT ____PT ____ST therapy at _____**Facility/ Home Health**. He/She was discharged on _____ (**Discharge Date**). I/He/She will be starting ___OT____PT____SP therapy services at BCM Innovative Therapies as of _____ (**Evaluation Date**).

_____ _____

Signature of Patient/ Parent or Legal Guardian Date

_____ _____

Signature of Witness Date

BCM INNOVATIVE Therapies, Inc.

Discovering possibilities.

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

BCM Innovative Therapies, Inc.

NOTICE OF HIPAA PRIVACY PRACTICE CONSENT

I HEREBY CONFIRM THAT THE HIPAA POLICY HAS BEEN PROVIDED TO THE CLIENT/PARENT/GUARDIAN AT TIME OF THIS ADMISSION

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with **BCM Innovative Therapies, Inc**. or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint must be filed within 180 days of when you knew or should have known that the act occurred.

The address for the office of Civil Rights is:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

THIS PAGE TO BE KEPT BY Patient/Parent/Guardian.