BODY MECHANIX PHYSICAL THERAPY, pllc

5848 Snyder Dr. Lockport, NY 14094

716-433-0070 phone 716-433-1171 fax email: bmxtherapy@gmail.com

RELEASE OF LIABILITY AND ASSUMPTION OF RISK

The individual named below (referred to as "I" or "me") desires to avail myself of the services (whether singular or plural, hereinafter referred to as the "Services") provided by Body Mechanix Physical Therapy, PLLC, a New York professional limited liability company with offices located at 5848 Snyder Drive, Lockport, New York 14094 (the "Company"). As lawful consideration for being permitted by the Company to receive the Services, I agree to all the terms and conditions set forth in this agreement (this "Agreement").

I AM AWARE AND UNDERSTAND THAT THERE MAY BE RISKS IN ENTERING THE PREMISES OF THE COMPANY AND RECEIVING THE SERVICES DUE TO CERTAIN PUBLIC HEALTH CONCERNS PERTAINING TO THE EMERGENCE OF A NEW STRAIN OF CORONAVIRUS ORIGINATING IN WUHAN, CHINA, AND THE WORLD HEALTH ORGANIZATION'S CLASSIFCATION OF SUCH AS A PANDEMIC, AND ALSO THE RECEIPT OF SUCH SERVICES. I ACKNOWLEDGE THAT I AM KNOWINGLY AND VOLUNTARILY ENTERING THE PREMISES OF THE COMPANY TO RECEIVE THE SERVICES WITH AN EXPRESS UNDERSTANDING OF THE DANGER INVOLVED AND HEREBY AGREE TO ACCEPT AND ASSUME ANY AND ALL RISKS OF INJURY, ILLNESS OR DEATH, WHETHER CAUSED BY THE NEGLIGENCE OF THE COMPANY OR OTHERWISE.

I hereby expressly waive and release any and all claims, now known or hereafter known, against the Company, and its officers, directors/manager(s), employees, agents, affiliates, members, successors, and assigns (collectively, "Releasees"), arising out of or attributable to my receipt of the Services, whether arising out of the negligence of the Company or any Releasees or otherwise. I covenant not to make or bring any such claim against the Company or any other Releasee, and forever release and discharge the Company and all other Releasees from liability under such claims.

This Agreement constitutes the sole and entire agreement of the Company and me with respect to the subject matter contained herein and supersedes all prior and contemporaneous understandings, agreements, representations, and warranties, both written and oral, with respect to such subject matter. If any term or provision of this Agreement is invalid, illegal, or unenforceable in any jurisdiction, such invalidity, illegality, or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable such term or provision in any other jurisdiction.

This Agreement is binding on and shall inure to the benefit of the Company and me and their respective successors and assigns. All matters arising out of or relating to this Agreement whether sounding in contract, tort or statute shall be governed by and construed in accordance with and enforced under the internal laws of the State of New York (including its statute of limitations) without giving effect to any choice or conflict of law provisions thereof to the extent such principles or rules would require or permit the application of the laws of any jurisdiction other than those of the State of New York. Any claim or cause of action arising under this Agreement may be brought only in the federal and state courts located in Niagara County, New York and I hereby consent to the exclusive jurisdiction of such courts.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTOOD ALL OF THE TERMS OF THIS AGREEMENT AND THAT I AM VOLUNTARILY GIVING UP SUBSTANTIAL LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE THE COMPANY.

Signed:

____

Printed Name:

____

Address:

____

____

Date: ______________________

I am the parent or legal guardian of the minor named above. I have the legal right to consent to and, by signing below, I hereby do consent in all respects to the terms and conditions of this Release of Liability and Assumption of Risk and agree that both the minor and I shall be bound by all of its terms and conditions.

Signed:

____

Printed Name of Parent or Legal Guardian:

____

Address:

____

____

Date: _________________

BODY MECHANIX PHYSICAL THERAPY, PLLC

Address: 5848 Snyder Drive Lockport, NY 14094 **Phone:** 716-433-0070 **Fax:** 716-433-1171

Date of Initial Visit (today): ______________________DOB: ___________________ Sex at birth: **M** or **F**

Name: First_______________________ MI______ Last__________________________ WEIGHT: _________

Address: ____

Phone: __________________________ Texts? O **Yes** O **No** Alternate PH: __________________________

Social Security Number: _______-_____-________ E-mail: ____

Emergency Contact/Phone #: ____

Referring Physician: ______________________________ PRIMARY CARE DR: ________________________

What are you seeking treatment for? ____

Has this ever been part of Workman's Comp Injury or Car accident? O **Yes** O **No** If Yes, Circle: **Auto** or **W/C**

Date of **injury**/aggravation: ________________ Please Circle: New Injury or Aggravation of Injury

Surgery Performed? **Y** or **N** Date of Surgery: __________ What was surgery? ________________

Follow up with referring MD? Date: _________________ History of **falls** in past 1yr? O **YES** O **NO**

Briefly describe the **history** of your injury or what made you seek treatment? (Please **describe**)

____

____

Have you had... X-Rays: O **Yes** O **No** MRI: O **Yes** O **No** **Where**? ______________________________

Is your sleep disturbed (if yes how many x's per night/wk)? __________________________________

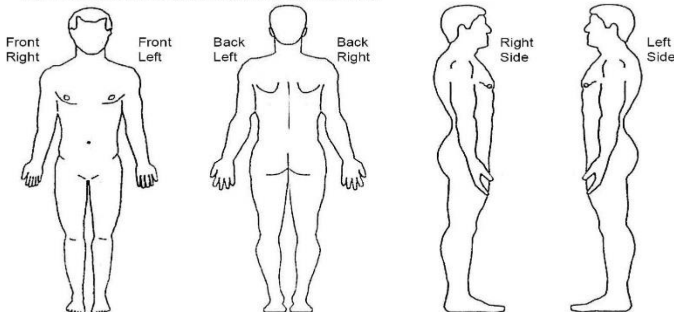
What Aggravates your discomfort? (**Please circle**):
sitting, standing, walking, stairs(up), stairs(down), sit to stand, bending, voiding, lying down

Occupation and Work Status: ____

**What do you hope to achieve by attending PT??____

Hobbies/Sports you do: ____

What would you like to be able to do or do better? ____



What is your pain? Pain Scale: 0 = None 5 = Moderate 10 = Extreme

	0	1	2	3	4	5	6	7	8	9	10
At worst:	○	○	○	○	○	○	○	○	○	○	○
Current:	○	○	○	○	○	○	○	○	○	○	○
At best:	○	○	○	○	○	○	○	○	○	○	○

Pain Description: (circle all that apply) Burning
sharp dull/achy throbbing shooting
numbness/tingling constant intermittent

Any Previous Physical Therapy? O **Yes** O **No** If yes, When? ___________________________________

General Health (please **circle** one): good fair poor other: _____________

Name:____

Medical History (your history):

Condition	Yes	No	Condition	Yes	No
High Blood Pressure			Allergies to medications		
Heart Disease , Heart Attack, Pacemaker			Head injury/dizziness/migraines		
Cancer			Depression/anxiety		
Osteoarthritis			Open Wounds		
Osteoporosis			Skin Condition		
Rheumatoid Arthritis			Metal Implant/Fragments		
Diabetes: type 1 or Type 2			Do you smoke? How much?		
Fracture: of__________________			Do you drink? How much?		
Stroke or TIA			Vascular Problems		
Infectious Disease			Neck or Back Problems		
Seizures/Epilepsy			Unexplained Weight Loss		
COPD/Bronchitis/Asthma			Pregnant Now		
Joint Replacements			Other medical? kidney		

If you answered YES to any of the above please explain: ____

**Please list any allergies to medications: ____

Please list any surgeries or provide the office with a list: ____

Current Medications: Prescription(dosage/frequency) please include vitamins & supplements:

____

____

**How did you hear about us(circle)? MD phone book attended before friend other:___________

PRIMARY INSURANCE INFORMATION

Insurance company Name: ________________________________ ID#:___________________________

Group #:____________ Name of Person Insured: __________________dob:____________ Relation: ____________________

Insured's Employer: ____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: ____

ID#:______________________________ Group #:______________________________

Name of Person Insured: __________________________ Relation: ____________________

Insured's Employer: ____

NO-FAULT INSURANCE (auto insurance)

No-Fault Carrier: ____

Date of Accident: __________________ No-Fault Claim #:__________________________

WORKMAN'S COMPENSATION

WCB#: __________________________ Carrier Case#: ____________________________ date of accident___________________

Employer: ____

****Patient Signature**: ____ Date: _____________

Release of Information I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. *This Release of Information will remain in effect until terminated by me in writing. This information may be released to: (PLEASE CIRCLE)

1.) Spouse ____________________________2.) Child(ren) _______________________ 3.) Other: ______________________ 4.) No.

****Patient Signature**: ____ Date: _____________

Name:____

Financial Policy of Body Mechanix Physical Therapy, pllc:

Body Mechanix Physical Therapy is dedicated to providing the best possible care for you in a warm comfortable environment. With this in mind, we have provided you with our policies to eliminate any confusion. It is our goal to keep your insurance and other healthcare requests as simple as possible and to make sure your healthcare experience is delivered with the thoroughness and superior quality you deserve. If at any time you have any questions, please call us at (716) 433-0070. It is our pleasure to help you.

Change of Information: It is important that you keep us updated with any changes in address, phone numbers, and insurances. Any changes will directly affect claims and the ability for us to contact you.

Referrals: We require some form of **script &/or referral/consultation** from another licensed healthcare practitioner prior to treatment. If this is not arranged or received prior to your visit, then **only** a consultation/evaluation will be performed during the initial visit. Treatment will begin post referral/consultation. You must contact your PCP to request a referral. We are not responsible for making sure you have a referral; you must check with your carrier.

Scheduling: Body Mechanix Physical Therapy typically schedules a full hour for each patient for your initial consultation. After your initial consult you will be scheduled in half hour time slots. Please let us know if you have special work/school needs.

Canceled/ Missed Appointments: If you must cancel an appointment, we ask you to call at least 24hrs before your scheduled appointment time. Any **missed** appointments, **late cancel** or **no show/no call** could result in a $25 charge**. Please keep your scheduled appointments.**

Insurance Coverage: We accept most insurance plans however, there are a few insurance plans we do not accept or participate with including Empire plan that will be processed as out-of –network but we will bill CIGNA (others) if you desire. We expect you to know your Physical Therapy benefits according to your plan prior to your visit. **We will help answer any questions you may have about your insurance plan but plans differ greatly so we hold you responsible to know your plan benefits. You will be responsible for any part not covered by your insurance**. We DO accept Medicare. If you do not have a secondary insurance plan you will be responsible for the 20% not covered by Medicare. If you have a secondary insurance, we will file that for you as well. You will be responsible for any part not covered by your Medicare and secondary insurance. Medicare Has a Yearly benefit maximum that varies per year. If you have Medicaid as a secondary you will not be responsible for balance on account unless it falls under your deductible for Medicaid. **The 2021 Therapy Max is $2,110.00 but changes yearly. It is our office policy to try to remain under this amount but should your care be considered "medically necessary" you would be allowed to continue therapy with special considerations (speak to the office).**

We would like you to understand there are no guarantees to the accuracy of the verification process or any payment amounts received from your insurance company. The final indicator of your coverage is the check and or the Explanation of Benefits (EOB). Therefore: it is your responsibility to monitor the accuracy of the EOB you receive and compare to the bills you receive from our office. Please call if there are ANY discrepancies! We are here to help YOU and we sometime make mistakes and would like to correct that for you.

Returned Checks: There is a $25 fee for every returned check. After 1 returned check we will ask that all future payments be made with cash.

Statement Fee: We will bill all balances on account for 1 statement without a fee. Should we need to send you any additional statements due to non-payment you will be charged a **$10 statement processing fee**. If you do not pay within 45 days of your statement you will be added to our "collections" accounts that will be turned over to the proper agencies and could begin to affect your credit. Please pay promptly or call the office to avoid these extra fees.

Re: Estimates on Deductibles and Procedures and Balances on Account

Due to recent changes in government and insurance policies, the providers of BODY MECHANIX PHYSICAL THERAPY, pllc are working to be proactive and give patients estimates for upcoming procedures and visits when they have deductibles and changes in co-payments. We will be collecting all balances on account as they become due (as we are notified by your insurance plan). **We will be asking for payment up front**. Our staff is working diligently to get you this information, but as you are aware, deductibles update on a daily basis. Our staff will inform you prior to your visit of the cost related to your visit. These services can **be** costly when you still need to meet your deductible and/or coinsurance. Should you decide to move forward and receive the service, our policy is to collect your portion at the time of the visit. Our goal is to give you this information prior to the service being rendered.

***Please read the guidelines above, check the appropriate box, sign and date that you understand and agree to our financial policy.* If at any time you have any questions, please call our office at (716) 433-0070. It is our pleasure to help you. Acceptance of financial policy:**

( )**Commercial and/or Medicare advantage (replacement) Plans/PPO's Health Insurance (ie.blue cross, aetna, ind health, univera)** – You will verify your coverage prior to your visit and we will file your claims with the understanding you gave us the correct insurance information. You are responsible for your ***co-pays, deductibles*** or any ***balances*** not covered by your ***insurance.*** (View above policy)

( )**Medicare Only** – this office files claims and if you do not have a secondary insurance that covers Medicare remainders you are responsible for 20% of the Medicare allowed amount according to their fee schedule. (view above policy)

( )Workers Compensation/No Fault – if you have notified your employer and have a claim number and it has been pre-verified by this office to bill the insurance carrier, there should be no charge to you. If, however your claim number is invalid for any reason, or you have been cut off benefits you acknowledge you are financially responsible for $100 for the evaluation and $50/visit thereafter. The Workman's Compensation Board changed their regulations eff 11/1/2021. You are eligible for 6- 8 weeks of Physical Therapy then you will need to return to your Physician.

I accept the financial policy of Body Mechanix Physical Therapy, PLLC.

****Patient Signature**: ____ Date: ______________

HIPAA-Your Health Information is Protected by Federal Law

What Information is Protected? -Information your doctors and other health care providers put in your medical record. -Conversations your doctor has about your care or treatment with others. -Information about you in your health insurers computer system. -Billing information about you from your clinic/healthcare provider. -You decide if you want to give permission before your health information may be shared. -If you believe your health information isn't being protected, you can: File a complaint with your health care provider or health insurer File a complaint with the US Government -You can ask your provider or health insurer questions about your rights.

Providers and health insurers are required to follow this law and must keep your information private by: -Teaching people who work for them how your information may and may not be shared. -Taking appropriate and reasonable steps to keep your health information secure.

To make sure your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:
-For your treatment and care Coordination.
-To pay doctors and hospitals for your healthcare.
-With family, friends or others you identify who are involved with your healthcare.

For more information: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Acknowledgement of Receipt of Notice of Privacy Practices: By my signature below, I hereby acknowledge receipt of the Notice of Privacy Practices (available upon request): Medical Information Release Form (HIPAA Release Form)

****Patient Signature**: ____ Date: ___________

CONSENT TO USE ELECTRONIC COMMUNICATIONS

BODY MECHANIX PHYSICAL THERAPY, pllc
Address: 5848 SNYDER DR, LOCKPORT, NY 14094
Email (if applicable): BMXTHERAPY@GMAIL.COM, WEBPT PORTAL, KAREO.COM PORTAL
Phone (as required for Service(s)): 716-433-0070
Website (if applicable): WWW.BMXTHERAPY.COM

The Physician has offered to communicate using the following means of electronic communication (“the Services”) [check all that apply]:

O EMAIL:	O Videoconferencing (including Skype®, FaceTime®)
O Text messaging (including instant messaging)	O Website/Portal
O Social media (specify):	O Other (specify):

PATIENT ACKNOWLEDGMENT AND AGREEMENT: I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician’s staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Physician may impose on communications with patients using the Services.
I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician’s staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician’s staff using these Services with a full understanding of the risk.
I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Patient name: ______________________________________
Patient address: ____
Patient home phone: ____
Patient mobile phone: ____
Patient email (if applicable): ____

****Patient Signature**: ____ Date: ___________

Name:____

APPENDIX

Risks of using electronic communication

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to use electronic communications). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

• Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
• Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
• Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
• Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
• Electronic communications can be forwarded, intercepted, circulated, stored,or even changed without the knowledge or permission of the Physician or the patient.
• Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
• Electronic communications may be disclosed in accordance with a duty to report or a court order.
• Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

<u>**If the email or text is used as an e-communication tool, the following are additional risks:**</u>

• Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
• Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

<u>**Conditions of using the Services**</u>

• While the Physician will attempt to review and respond in a timely fashion to your electronic communication, the Physician cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters.
• If your electronic communication requires or invites a response from the Physician and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
• Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.
• Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
• The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
• You and the Physician will not use the Services to communicate sensitive medical information about matters specified below [check all that apply]:

O Sexually transmitted disease
O AIDS/HIV
O Mental health
O Developmental disability
O Substance abuse
O Other (specify):

• You agree to inform the Physician of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician in writing.
• Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
• The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider. Patient initials______ APPENDIX CONTINUED

Instructions for communication using the Services To communicate using the Services, you must:

• Reasonably limit or avoid using an employer's or other third party's computer.
• Inform the Physician of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate via the Services.

If the Services include email, instant messaging and/or text messaging, the following applies:

• Include in the message's subject line an appropriate description of the nature of the communication (e.g. "prescription renewal"), and your full name in the body of the message.
• Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to the physician.
• Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing "read receipts" to be sent.
• Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
• Withdraw consent only by email or written communication to the Physician.
• **If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services**. Rather, you should call the Physician's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.
• Other conditions of use in addition to those set out above: (patient to initial)

I have reviewed and understand all of the risks, conditions, and instructions described in this Appendix. Patient Signature:
Date:

ATTN: workman's comp patients

As per the Workman's Compensation Board eff 10/1/11 Physical Therapy Services are limited by Guidelines that must be followed by our office.

If you are coming to physical therapy and covered by Workman's compensation you are allowed 6weeks of Physical Therapy for NECK, BACK, and KNEES and 8weeks for SHOULDERS (12weeks for shoulder if you had surgery)

What this means to you?

- You will be in therapy for the allowed amount of time and you will need a script from your MD for initial treatment and may be required to provide us with a script for continued PT after 30day (from date of initial script)
- At the 6weeks (NECK, BACK, KNEES)/8-12 weeks (shoulder) you will be **discharged** to return to your MD for a follow up. At this time you should discuss with your MD if you are to continue therapy. If they would like you to continue you can ask the office to submit the MG-2 on your behalf.
- **We will not be able to continue therapy until AFTER your MD has submitted a request (MG-2) to your workman's comp carrier and they have approved further treatment.**
- A script to continue PT does NOT mean you have been approved; you must wait for an approval of the MG-2 request. Once your MD calls you or you receive the approval you should call our office to schedule an appointment.
- The MD can fax the approval to our office at 716-433-1171