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** 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)

____

____

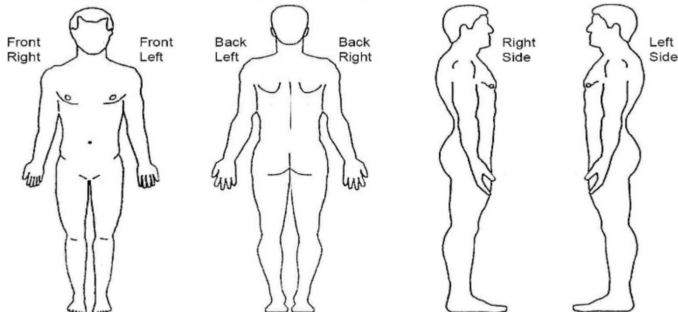
Have you had any X-Rays _____________MRI ______________ where______________________

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

What Aggravates your pain? (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??____



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

Pain Location: ____

Any Previous Physical Therapy? O yes O no If yes,When and for what? ____________________

Have you attended here before (if yes; which body part)? ____________________________________

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

Medical 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: _____________________________ ID#:________________________ Group #:___________

Name of Person Insured: ________________dob:___________ Relation: __________________

Insured's Employer: ____

SECONDARY INSURANCE INFORMATION

Insurance Company: __________________________ 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.

****Signature**: ____ **Date:**________________

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 The Empire plan that will be processed as out-of –network but we will bill them 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 or if you give us incorrect insurance info**. 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 2022 Therapy Max is $2,230 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) but would stay under $3,000 to avoid medical review.**

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 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. If you have received therapy and are switching offices we can try to get visits used but you are responsible to know how many visits you have used and have left as we will not be able to get an accurate number from your insurance.

***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. We may agree to bill your Commercial Ins to avoid charges to you. The Workman's Compensation Board allows for 15visits in 6- 8 weeks time frame initially then you will need to return to your Physician.

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

Signed: ____ dated:____________________

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)

**** 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: _________________

ATTN: workman's comp patients

As per the Workman's Compensation Board 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 15 visits in a 6-8 week time frame for Physical Therapy on NECK, BACK, KNEES, HIPS/GROIN, WRISTS, ANKLE, FEET, ELBOW , HAND, FOREARM and SHOULDERS (12weeks for shoulder if you had surgery) **THIS applies if you have not had previous therapy through Workman's comp on these injuries.

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)
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- At the 6-8weeks/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 PAR request on your behalf.
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- **We will not be able to continue therapy until AFTER your MD has submitted a PAR request to your workman's comp carrier and they have approved further treatment and we have received a copy of such an approval.**
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- A script to continue PT does NOT mean you have been approved; you must wait for an approval of the PAR request. Once your MD calls you and/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