BEAR CANYON
THERAPY ASSOCIATES

5130 San Francisco Rd NE • Suite B
Albuquerque, NM 87109
Office: 505.823.2411 • Fax: 505.858.0650
www.bearcanyontherapy.com

NEW PATIENT INFORMATION. (Fields marked with an * are **not** required)

Date: _____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Date of Birth: _____ **Sex** (please circle) **MALE FEMALE**

***Social Security:**_____ **Employer:** _____ **Work Phone:**_____

Occupation: _____

Responsible Party for Patient: _____ **Telephone:** _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:**_____

Telephone 1: _____ **Telephone 2:** _____

RELEASE OF INFORMATION

I hereby authorize my physician to release any medical information to this facility upon request. I certify the above information to be true and correct to the best of my knowledge. I will notify this facility of any changes to the above information.

I hereby authorize Bear Canyon Therapy Associates to furnish information to insurance carriers concerning my illness and treatments and I hereby assign Bear canyon Therapy Associated all payments for medical serviced rendered to me or my dependents.

I have been informed of my insurance benefits and eligibility and I understand that I am responsible for the deductible/co-pay/co-insurance in accordance with my insurance policy and for serviced not covered by my insurance.

Signature of Patient/Responsible Party: _____ **Date:** _____

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Cancellation Policy

In order to respect the value of our therapists' time and the ability of other patients to receive therapy in a timely manner.

Please call at least 24 hours in advance to cancel or reschedule an appointment.

At the discretion of our staff, the clinic reserves the right to assess a **$25.00 fee** for canceling or rescheduling less than 24 hours in advance or failure to attend a scheduled appointment in a timely manner.

By signing this page you acknowledge this policy.

Signature of Patient/Responsible party: _____ Date: _____

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Acknowledgement of receipt

Notice of Privacy Practices

By signing below you are acknowledging our notice of privacy practices.
To obtain this form please ask a representative at the front desk.

Name of Patient: _____

Signature of Patient: _____

If signing on behalf of the patient:

Patient Representative Name: _____

Patient Representative signature: _____

Date:_____

Witnessed by (Print name): _____

If you would like to give permission to a spouse/family member to obtain a copy of your medical records on your behalf, please ask for a Medical Records release Form

Or

I authorize _____, _____
(Name of Authorized Person) (Relationship to patient)

To obtain my medical records on my behalf.

Signature of patient: _____ Date signed:_____

You make revoke this authorization at any time. Should you wish to do so, please let a member of our staff know.

Bear Canyon Therapy Associates

Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing specialist. We are dedicating to providing the best possible care and service to you and regard your complete understanding on your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance either you or your health coverage carrier, full payment is due at the time of service. We accept check, MasterCard, Visa, Discover and American Express for your convenience.

Your Insurance

***If you are a self-pay patient; we will NOT bill your insurance.**

We have made prior arrangements with many insurers and other health plans to accept assignment of benefits. We will bill those plans which we have contracted with and will only require you to pay the authorized co-payment and deductible at the time of service. It is the policy of our office to collect the co-payment and unmet deductible if applicable when you arrive for your appointment.

Any unmet deductibles and/or balances remaining after your insurance has paid are your financial responsibility. **Verification of benefits is not a guarantee of payment.** In the event that your health plan determines a service to be "not covered," you will be responsible for the complete payment.

For all services rendered to minor patients, we will look to the adult accompanying the patient, parent or guardian with custody for payment.

I have read and understand the financial policy of Bear Canyon Therapy Associates and I agree to be bound by its terms. I agree that should I fail to pay any amount due, I will be responsible for any collection and/or attorney fees. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

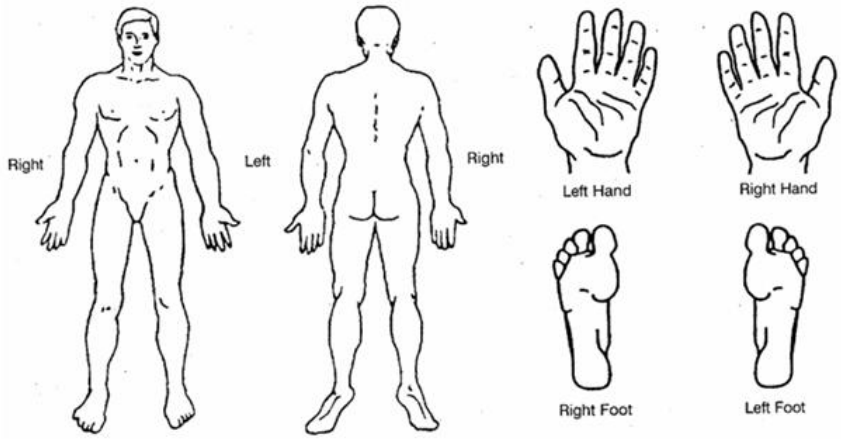
Signature of Patient or Responsible Party **Date:**

You can expect to receive a monthly statement while receiving treatment at this facility, detailing all transactions and notifying you of any balances due.

Pain Profile

Mark an "X" on the drawing below, the locations where you have experienced pain in the last week.
Grade each "X" using the following scale.

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild		Discomforting		Distressing		Horrible		Excruciating



Have you had this problem/injury before? YES NO

If yes, approximate dates: _____

What makes your pain better: _____

What makes your pain worse? _____

Is your pain: Please circle one **Getting better? Getting worse? Staying the same? Constant? Intermittent?**

With this condition, when did your pain start? _____

What is your goal in therapy? _____

Do you have any special learning needs?
PLEASE MARK ALL THAT APPLY:

- ☐ **Visual**
- ☐ **Hearing**
- ☐ **Reading**
- ☐ **Learning**
- ☐ **Speech**
- ☐ **Other _____**

Is there anything else we should know about that may affect treatment and/or progress? (Eg. Language barriers, cultural or Religious beliefs, scheduling or transportation issues?

_____

_____

Patient Name (printed): _____

Patient Signature: _____ Date: _____ Therapist Signature: _____ Date: _____

PATIENT HEALTH HISTORY

Patient Name: _____ Date Completed: _____

To provide the best care possible, we need to know if you have pre previously had any of the following conditions:

YES	NO	
___	____	**Arthritic Condition**
___	____	**Asthma or other Breathing problems?**
___	____	**Cancer or Tumors of any type?**
___	____	**Chest Pain?**
___	____	**Diabetes: If yes, are you insulin Depended? _____**
___	____	**Dizziness?**
___	____	**High Blood Pressure?**
___	____	**Irregular Heartbeat?**
___	____	**Stroke?**
___	____	**Seizure, Epilepsy, or nervous Disorders?**
___	____	**Are you pregnant?**
___	____	**Are you now or have you been an IV drug user?**
___	____	**Are you HIV positive?**
___	____	**Are you over 65?**
___	____	**Are you used to vigorous exercise?**
___	____	**Do you have joint replacements or metal implants?**
___	____	**Do you have any healing fractures?**
___	____	**Do you have bowel or bladder control problems?**

Allergic Conditions: _____

Do you smoke? _____ Packs/Cartridges per day? _____

Diagnostic Tests (please provide date): X-Rays/MRI: _____ Injections: _____

EMG: _____ CT Scan: _____ Myelogram: _____ Other: _____

Have you had previous Physical Therapy Treatment? If yes, where and how long for:

_____

Chiropractic treatment: _____ Work Hardening/Conditioning: _____

Assistive Devices: _____

Back/Neck Pillows: _____ Back Brace/Belt: _____

List any condition you have not listed above: _____

_____

I attest the above information is true and correct.

_____ _____

Signature of Patient/Responsible Party Date

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Patient Medication List

Name: _____ Date:_____

Medication	Dosage	Frequency	Duration