BIG COUNTRY REHABILITATION, LLC

Patient Information

(PLEASE PRINT LEGIBLY)

Today's Date:______________________ Email Address:_____________________________________

Last Name:________________________________ First Name: ____________________ MI: _______

Mailing Address: ____

City_______________________________ State________________________ ZIP________________

Home Phone:____________________ Cell Phone:_________________ Work Phone_______________

DOB:___________________________ Age: _________________________ Sex: _________________

If the patient is a dependent (select one): ☐Natural Child ☐ Step Child ☐Foster Child ☐Grand Child ☐Niece/Nephew ☐Ward of the Court ☐Handicapped Dependent

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Social Security Number_______________________________ Student ☐ Yes ☐No

Patient's Employer____ ☐ Full Time ☐ Part Time

Occupation _______________________Employer Address____________________________________

City___________________________ State______________Zip_________ Phone_________________

Primary Physician____

Referring Physician____

Diagnosis________________________________ Date of Injury/Onset___________________________

Spouse/Guardian/Parent Name____________________________________ Relationship____________

DOB________________ Social Security Number______________________ Phone________________

Mailing Address______________________________City______________State_______Zip________

Employer__________________________________ Occupation_________________________________

Emergency Contact Name:___________________________ Phone:_____________________________

INSURANCE

Who is responsible for this account?_________________ Relationship to Patient___________________

Primary Insurance____

Address__________________________City______________State_____________Zip______________

ID/Case#____ Group#__________________________

Insured Name_____________________DOB_______________SSN#____________Gender__________

Secondary Insurance____

Address__________________________City______________State_____________Zip______________

ID/Case#____ Group#__________________________

Are you or could you be pregnant? ❑ Yes ❑No
Tobacco Use? ☐ Yes ❑No How often? ____________
Are you allergic to: Adhesive tape: ❑ Yes ❑No Any medication: ❑ Yes ❑No

If "YES": please list:____
Please list surgical procedures:_______________________________________
____
____
Other pertinent information:____

YOUR Medical History Please indicate if **YOU** have a history of the following:

☐ Alcohol Abuse	☐ Heart Disease	☐ Neuritis or Neuralgia
☐ Anaphylaxis	☐ Heart Pain/Angina	☐ Osteoporosis
☐ Anemia	☐ Heart Palpitations	☐ Polio
☐ Anesthetic Complication	☐ Hepatitis A	☐ Prostate Cancer
☐ Anxiety Disorder	☐ Hepatitis B	☐ Rectal Cancer
☐ Arthritis	☐ Hepatitis C	☐ Seizures/Convulsions
☐ Asthma	☐ High Blood Pressure	☐ Severe Allergy
☐ Autoimmune Problems	☐ High Cholesterol	☐ Sexually Transmitted Disease
☐ Birth Defects	☐ HIV	☐ Shortness of Breath
☐ Bladder Problems	☐ Hives	☐ Sprains
☐ Bleeding Disease	☐ Joint Dislocations	☐ Skin Cancer
☐ Blood Clots/DVT	☐ Kidney Disease	☐ Steroid Use
☐ Blood Transfusions(s)	☐ Lacerations	☐ Steven-Johnson Syndrome
☐ Bowel Disease	☐ Liver Cancer	☐ Stroke
☐ Breast Cancer	☐ Liver Disease	☐ Suicide Attempts
☐ Broken/Cracked Bones	☐ Loose Joints	☐ Swelling of the Hand/Feet/Ankles
☐ Bursitis, Sciatica or Lumbago	☐ Lung/Respiratory Disease	☐ TB(Tuberculosis)
☐ Cervical Cancer	☐ Lung Cancer	☐ Thyroid Problems
☐ Chest Pain	☐ Low Blood Pressure	☐ Ulcer
☐ Concussion/Head Injury	☐ Major Traumatic Injury	
☐ Colon Cancer	☐ Marfan's Syndrome	☐ Other Disease, Cancer /Significant Medical Illness
☐ Depression	☐ Mental Illness	
☐ Diabetic	☐ Migraines	
☐ Heart Attack	☐ MRSA Infection or Colonization	☐ NONE of the Above

FAMILY Medical History Please indicate if **YOUR FAMILY** has a history of the following:
(**ONLY** include parents, grandparents, siblings, and children)

☐ Family History Unknown

☐ Alcohol Abuse	☐ Breast Cancer	☐ Migraines
☐ Anaphylaxis	☐ Colon Cancer	☐ Osteoporosis
☐ Anemia	☐ Depression	☐ Rectal Cancer
☐ Anasthetic Complication	☐ Diabetes	☐ Seizures/Convulsions
☐ Arthritis	☐ Heart Disease	☐ Severe Allergy
☐Asthma	☐ High Blood Pressure	☐ Steven-Johnson Syndrome
☐ Bladder Problems	☐ High Cholesterol	☐ Stroke
☐ Bleeding Disease	☐ Kidney Disease	☐ Thyroid Problems
☐ Blood Clots/DVT	☐ Lung/Respiratory Disease	☐ Other Cancer

☐ None of the Above

D ate: **Patient Name:**

Height and Weight	Height: Weight:
Date of Injury	
Where on your body?	
Chief Complaint:	What happened? How long has this been going on? Where?
What goals would you like to accomplish with therapy?	
How is your general health?	

Medical History	Cancer/Pacemaker/Seizures? List anything you have been treated for:
Pain Rating	Worst: 0-1-2-3-4-5-6-7-8-9-10 Current: 0-1-2-3-4-5-6-7-8-9-10 Best: 0-1-2-3-4-5-6-7-8-9-10 Better with: Worse with:
X-ray/MRI/Injections	List any diagnostic tests you have had:
Medications:	List your current medications and why:

Welcome! Thank you for selecting our office. It is our goal to provide your physical therapy needs as thoroughly and efficiently as possible. To do that, we need to work with you as a team.

As part of the team you need to know and understand a few things. Before we begin, we will discuss and explain our treatment plan. Depending on your progress the plan may need to be changed. An estimate of the total fee for your treatment is virtually impossible because we cannot tell how long it will take you to progress. We will be able to tell you how much each treatment costs. If you are uncertain of any change or cost feel free to ask. We are more than happy to answer your question. Your physician will then be contacted for permission to treat a new diagnosis.

Our policy regarding payment for our professional services is as follows:

A: Cash, check or major credit card will be accepted at the time of treatment. Any account not paid in full 90 days after treatment will bear interest at the rate of 1.5% per month or 18% per annum.

B: Treatment involving any laboratory work, braces, orthotics or prosthetic devices may require a percentage of the total fee be paid before treatment begins or the device is ordered. This is necessary to cover the laboratory fees or the cost of the device we must pay in advance.

C: In the event we have to use an attorney to collect any unpaid balance due for services to you or your family by signing the information form upon your first visit you agree to pay all costs of collection, including all attorney fees whether suit is filed or not.

INSURANCE: As a courtesy to our patients we will file your primary insurance and secondary insurance. Please check your insurance policy prior to service to be sure physical therapy / occupational therapy is covered.

MEDICARE:
Big Country Rehabilitation, LLC accepts Medicare assignment, Medicare payment will be made directly to the provider. The provider agrees to accept the Medicare allowed amount for covered services. The beneficiary may be billed for the 20% coinsurance, any unmet deductible and for services not covered by Medicare. A Doctor’s referral is required every 30 days.
Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy services. There are limits on these services.
The therapy cap limits for 2020 are:

- $2080.00 for physical therapy
- $2080.00 for occupational therapy

Softgoods or Durable Medical Equipment are not a covered benefit (ie, knee brace, orthotics, back brace).
Medicare requires that patients see their physician every 30 days.

MEDICAID:
There is a 20 visit limit for all Medicaid patients. Softgoods or Durable Medical Equipment are not a covered benefit (ie, knee brace, orthotics, back brace).

WORKERS’ COMPENSATION:
We will process Workers’ Compensation; however, you are required to let us know that you have a workers’ compensation claim, and you must provide us with your case number, date of injury,

social security number and employer's address. If we do not receive a case number from you, or if your claim is denied you will be responsible for all charges incurred. If your case is under objection you will receive a bill from us until your case is resolved. You must be in constant contact with your caseworker. If there is new information please let us know.

CAR INSURANCE:
Stay in contact with your claims adjuster. If there is new information please let us know.

AUTHORIZATION AND/OR REFERRAL REQUIRED
YES – REFERRAL IS REQUIRED FOR ALL INSURANCES.
IF IT IS WORKERS' COMPENSATION AUTHORIZATION IS REQUIRED.

We at Big Country Rehabilitation, LLC strive to help you with all your insurance questions or concerns. As a reminder, any benefits quoted are not a guarantee of benefits. By signing this form, you are responsible for all accrued charges during your treatment at Big Country Rehabilitation, LLC.

____
Patient Signature Date

____
Office Staff Signature Date

BIG COUNTRY REHABILITATION, LLC

MEDICARE ONE TIME AUTHORIZATION:

I_______________________________, request that payment of authorized Medicare benefits be made to Big Country Rehabilitation, LLC on my behalf for any services, physical therapy or softgoods, furnished to me by Big Country Rehabilitation, LLC. I authorize Big Country Rehabilitation, LLC to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services. If "other health insurance" is indicated in item 9 of the HCFA-1500 in the form of, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized release of the information to the insurer or agency shown. In Medicare assigned cases, Big Country Rehabilitation, LLC agrees to accept the charge determination of the Medicare carrier as the full coverage. The patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the character determination of the Medicare carrier.

____

Beneficiary Signature Date

ASSIGNMENT AND RELEASE

I, the undersigned certify that my dependent or I have insurance coverage with, ______________

____

and assign directly to Big Country Rehabilitation, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize that Big Country Rehabilitation, LLC can release all information necessary to secure the payment of benefits. I further authorize Big Country Rehabilitation, LLC to contact the Insurance Commissioner on my behalf in the event of insurance problems. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

____

Relationship Date

-I HAVE READ THE ABOVE AND I AGREE TO THE TERMS.
-I HEREBY ACKNOWLEDGE RECEIPT OF A COPY OF THIS FORM.
-I HEREBY AUTHORIZE BIG COUNTRY REHABILITATION, LLC TO PERFORM SUCH TREATMENTS AND PROCEDURES THE PHYSICIAN HAS ORDERED FOR TREATMENT.
-I UNDERSTAND THAT BIG COUNTRY REHABILITATION, LLC WILL HOLD ALL MY INFORMATION REGARDING MY CONDITION CONFIDENTIAL.
-I HEREBY GIVE PERMISSION TO RELEASE NECESSARY INFORMATION TO MY INSURANCE COMPANY, ATTORNEY, MEDICAL DOCTOR, MEDICARE, MEDICAID OR WORKERS COMPENSATION.

____

Name of Patient (Print) & Signature of RESPONSIBLE PARTY

BIG COUNTRY REHABILITATION, LLC

STANDING AUTHORIZATION FOR RELEASE OF INFORMATION TO SPECIFIC PERSON(S)

NAME:______________________________ DOB:________________
ADDRESS:___________________________ SSN:_________________
PHONE:______________________________

May we reach you or the below mentioned persons by phone?_______________

I authorize Big Country Rehabilitation, LLC to share information regarding my treatment, or payment for treatment, with the following individuals:

□ My spouse or partner (name)____
□ My son or daughter (name)____
□ Other individual (name)____
□ None

ACKNOWLEDGEMENT
I understand that any information disclosed by this authorization may be subject to disclosure by the recipient and will no longer be protected by HIPAA. The Facility and all personnel covered under this entity are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

EXPIRATION
I understand that I may revoke this authorization by submitting a written notice to Big Country Rehabilitation, LLC. This notice will remain in effect until such time it is revoked.

PATIENT SIGNATURE:________________________________ DATE:________________

REPRESENTATIVE'S SIGNATURE:______________________ DATE:_______________

RELATIONSHIP TO PATIENT IF NOT NAMED ABOVE:___________________________

BIG COUNTRY REHABILITATION, LLC

BIG COUNTRY REHABILITATION, LLC
PHYSICAL/OCCUPATIONAL THERAPY

Certain restrictions may apply with your insurance company for Physical Therapy and Occupational Therapy services. We advise you to contact your insurance company by using the toll-free number on the back of your insurance card to verify coverage. Some questions you may want to ask are:

1. Does my insurance cover Physical and/or Occupational Therapy Services?

2. If under treatment of a Workers' Compensation claim, will Physical and/or Occupational Therapy Services be covered? **(These services must be authorized. If not, I understand I will be responsible.) I understand if I do not attend my appointment and I do not cancel, my employer will be notified.**

3. How much of my $2,080.00 PT / $2,080.00 OT Medicare cap is remaining? (**I understand that supplies such as: Exercise Bands, Electrodes and Iontophoresis Patches are not covered by Medicare, and I am responsible for these purchases.)**

4. Are there any restrictions on where I can receive these services?

5. Is this provider in network with my insurance?

6. Are there financial limitations on Physical Therapy services?

7. Does my insurance require prior authorization?

8. Does my insurance cover "iontophoresis and phonophoresis"? **(You do need to ask this if you will be receiving these treatments.)**

9. Does my insurance cover miscellaneous supplies I may receive such as: braces, splints, exercise bands, etc.?

- If I cannot make an appointment, it is my responsibly to call and cancel. I understand that if I do not call to cancel, I risk being removed from any further scheduled appointments that I've made.

- **I have read the above questions and understand it is my responsibility to check my insurance coverage.**
  (A copy of this form must be signed and will be place in the Patient's File)

____ ________________________

Signature of Patient or Guardian if Patient is a Minor Date

BIG COUNTRY REHABILITATION, LLC

HIPAA NOTICE OF PRIVACY PRACTICES

Big Country Rehabilitation, LLC

Effective Date: April 14, 2003

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY**

WHO WILL FOLLOW THIS NOTICE:
Big Country Rehabilitation, LLC

OUR PLEDGE REGARDING HEALTH INFORMATION:
We are required by law to make sure that health information that identifies you is kept private; to give you this notice of our legal duties/privacy practices with respect to health information about you; and to follow the term of the notice that is currently in effect.

HOW WE USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that we use and disclose health information. Not every use of disclosure in a category will be listed. However, all of the ways are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at a doctor's office or other health care providers to whom we may refer you. For example, we may contact your physician's office and speak with a nurse regarding any concern we may have about unusual swelling associated with your ankle rehabilitation.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your visit so your health plan will pay us to reimburse you for your treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our facility. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you and documenting that care.

As Required By Law: We will disclose health information about you when required by federal, state, or local law.

Military or Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities of the Department of Veterans Affairs as may be applicable.

Workers' Compensation: We may release health information about you for Workers' Compensation or other similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include but are not restricted to reporting reactions to medications or problems with products and notifying people of recalls of products they may be using.

Health Oversight Activities: We may disclose health information about you to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, and licensure.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a court order, subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process.

Coroners and Health Examiners: We may release health information to a coroner or health examiner.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to a correctional institution or law enforcement official.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:
You have the following rights regarding health information we maintain about you.

Right to Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain. Usually this includes health and billing records. You must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. Your request will generally be approved unless there are legal or medical reasons to deny the request. If you are denied access to health information, you may request that the denial by reviewed.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment form please contact the Privacy Officer in writing and a form will be mailed to you. Completion of the form must either be legibly handwritten or typed and returned to the Privacy Officer. You must provide a reason that supports your request for an amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available;
- is not part of the health information kept by us or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment that we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting Disclosure: You have the right to request a list of accounting for any disclosure of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. To request this List of Disclosure, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will not notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures within 30 days of your request.

Right to Request Restriction: You have the right to request a restriction of limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, such as a family member or friend. For example, you could ask that we not disclose information to your spouse about treatments. ***We are required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you.***

IF we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request, in writing, to the Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail to a post office box. To request confidential communications, you must make your request, in writing, to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. This notice will contain, on the first page, in the top right corner, the effective date. In addition, each time you register for treatment, we will offer you a copy of the current notice in effect if our records indicate you have not been provided with the revised or changed notice.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint, contact the Privacy Officer. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

Contact Information:

The name and address of the person you can contact for further information or to request any forms concerning our privacy practices is:

Kate Kysar
469 South Mountain View Street, Suite 2
Powell, WY 82435-2535
307-754-1235

Effective Date: This notice is effective on or after September 19, 2018

Acknowledgment of Receipt of this Notice:

We will request that you sign a separate notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date that the notice was provided for you. This acknowledgement will be filed with your records.

Please sign the following acknowledgement.

I, ____ received a copy of the Notice of Privacy

Practices from Big Country Rehabilitation, LLC or a designated affiliate on the _____ day of __________________.

This acknowledgement will be filed with your records.

MANDATORY SCREENING (PLEASE COMPLETE)

Instructions:
Choose the best answer for how you have felt over the past **week:**

1. Are you satisfied with your life? Yes No
2. Have you dropped many of your activities and interests? Yes No
3. Do you feel that your life is empty? Yes No
4. Do you often get bored? Yes No
5. Are you in good spirits most of the time? Yes No
6. Are you afraid that something bad is going to happen to you? Yes No
7. Do you feel happy most of the time? Yes No
8. Do you often feel helpless? Yes No
9. Do you prefer to stay at home, rather than going out and doing new things? Yes No
10. Do you feel you have more problems with memory than most? Yes No
11. Do you think it is wonderful to be alive now? Yes No
12. Do you feel pretty worthless the way you are now? Yes No
13. Do you feel full of energy? Yes No
14. Do you feel that your situation is hopeless? Yes No
15. Do you think that most people are better off than you are? Yes No