CONSENT TO TREAT AND CONDITIONS OF ADMISSION

1. CONSENT TO REHABILITATION PROCEDURES: The undersigned consents to the procedures which may be performed during this and future out-patient physical therapy and occupational therapy visits that are performed at Buffalo Rehab Group Physical Therapy and Occupational Therapy, PLLC (the Company). I/We consent to examination, therapy procedures and therapy care given to the patient by or under the supervision of the physical therapist (PT) and occupational therapist (OT).
2. LEGAL RELATIONSHIP BETWEEN BUFFALO REHAB GROUP AND EMPLOYEES: All PTs, Physical Therapist Assistants (PTA), OTs, and Occupational Therapist Assistants (COTA) are employed by the Company. The Company serves as a medical teaching facility; therefore, PT / OT students and PTA / COTA students may be involved in your care under the supervision of an attending PT, OT, PTA or COTA.
3. NO SHOW / CANCEL POLICY: The undersigned agrees, whether he/she signs as agent or as a patient, that in consideration of the services to be rendered to the patient, he/she hereby acknowledges that if they no show or cancel or appointment within 24 hours for three consecutive times, they will be subject to discharge from care. A new referral and evaluation would need to be performed for continued care to occur.
4. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she sign as agent or a patient, direct payment to the Company of any insurance or other applicable (e.g. Medicare, Commerical Insurance) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, at rate not to exceed the Company's regular charges. It is agreed that payment to the Company, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. **Any pre-certification of insurance benefits is the patient's sole responsibility;** however, the company will make every effort to get this information in advance of the first visit. The undersigned authorizes payment of Medicare/Insurance benefits to be made on behalf of the patient for all services furnished by the Company. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.
5. PHOTOGRAPHING AND VIDEOTAPING: The Company may photograph, film, videotape, or otherwise make video and/or audio recordings of the patient only for the purposes of diagnosing and treating the patient's condition. No photograph or videotape will be used for any other purposes other than treatment without the patient's written consent.
6. DISCLOSURE OF HEALTH INFORMATION: I understand that the Company is a health provider who must comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA protects the privacy of individually identifiable health information. The Company Notice of Private Practice outlines your rights and responsibilities regarding your medical information and who to contact if you have any concerns regarding your medical information. Your initials below acknowledge that you have been given a copy of the Company's Notice of Privacy Practices.

Patient's Initials: _____ Date:_____

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accepts and agrees to its' terms.

_____

Patient/Guardian Signature **Date** **Print Patient Full Name**

FINANCIAL POLICY FOR BUFFALO REHAB GROUP PHYSICAL and OCCUPATIONAL THERAPY, PLLC

The information below explains the financial policies of Buffalo Rehab Group Physical and Occupational Therapy, PLLC (the Company)

- As a service courtesy for you, we check your insurance coverage and benefits for each episode of care. The payers do not guarantee coverage to us when we check benefits and see therapy visits so please self-verify your individual coverage and understand your insurance policy.

- Therapy services are billed on per diem or time-based procedure codes. Your therapist will provide care specific to your needs and will choose the appropriate procedure codes based on the procedures performed. Your therapist will be happy to explain the procedure codes if you have any questions.

- At the time of your first visit, we will provide you with an ESTIMATE of the amount of money that you will need to pay per visit based on the information we have received from your insurance. This estimate does not guarantee payment by your insurance.

- The amount not covered by insurance will be ESTIMATED and explained to you on your first visit. This amount is payable on the date that services are rendered when you check in.

- When you have not met your deductible, we will request an ESTIMATED PAYMENT from you that is applied towards your deductible. You will receive a bill for the remainder of the insurance allowable once the claim has been filed.

- Insurance companies have their own schedule of what they consider to be "usual and customary." These fees often vary between plans. Our charges are based on the time and the type of procedures used by your therapist for each session. If we are in network with your insurance, you will be responsible for the amount "allowed" by your insurance for each procedure based on your insurance contract. It is impossible for us to know the details of each individual policy.

- Your insurance is in an agreement between you, your employer, and the Insurance carrier. **We encourage you to contact your insurance company to better understand your benefit for therapy services.**

- If you have had recent treatments and/or procedures that should apply to your deductible, it may not have been billed by the hospital or physician's office yet and therefore may not be listed when we check your benefits. **Please contact your insurance if you feel that your deductible information is incorrect.**

- If you have a co-insurance percentage that you are expected to pay, we will collect an estimated amount on that co-insurance and **you will receive a bill** for the difference between what you paid. Co-payments (flat amounts per visit) will be collected after each date of service.

- **Financial Agreement:** The undersigned agrees whether he/she signs as an agent or as a patient, that in consideration of services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the Company in accordance with the regular rates and terms of the Company.

Patient/Guardian Signature:_____Date:_____

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the last page of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are aphasic, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks the therapist about your range of motion progress following surgery.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

CHANGES TO THE TERMS OF THIS NOTICE

WE CAN CHANGE THE TERMS OF THIS NOTICE, AND THE CHANGES WILL APPLY TO ALL INFORMATION WE HAVE ABOUT YOU. THE NEW NOTICE WILL BE AVAILABLE UPON REQUEST, IN OUR OFFICE, AND ON OUR WEB SITE.

OTHER INSTRUCTIONS FOR NOTICE

- This notice is effective 1/1/2021
- For questions or concerns regarding your privacy with Buffalo Rehab Group Physical Therapy, PC, please contact the Buffalo Rehab Group Physical Therapy, PC Privacy Officer

  Jeffrey Woodrich PT, CEO & President
  2100 Union Road West Seneca, NY 14224
  jeff@buffalorehab.com

HIPAA Release Form

Patient Name: _____ DOB:_____

Release of Information:

I authorize the release of information including diagnosis, records, examination rendered to me and claims information. The information may be released to:

( ) Family (list relation) _____

( ) Other _____

( ) Do not release to anyone

1. Right to Revoke
    a. I understand that I may revoke this authorization at any time by submitting a written request to Buffalo Rehab Group. Revocation will not apply to information already released based on this authorization.
2. Voluntary Authorization
    a. I understand that Buffalo Rehab Group will not condition treatment, insurance enrollment, or eligibility for benefits on signing this form.
3. Potential for Re-Disclosure
    a. I understand that information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by HIPAA.

Signature: _____ Date: _____

If signed by a legal representative:

I certify that I am authorized to act on behalf of the patient as:

( ) Parent of Minor

( ) Legal Guardian

( ) HealthCare Proxy

No Show Policy

For any patient who no shows or cancels within 24 hours for 3 consecutive appointments, that patient will be discharged. The patient will need to wait 1 month and receive an additional referral from the doctor before they can return. Their next appointment would be a new case and evaluation.

Procedure

1. **Warning of No-Show Policy**
    a. Patients will be given appropriate notice of the no show policy.
2. **Reminder of No-Show Policy**
    a. If a patient no shows or cancels two consecutive appointments, a reminder should be made to the patient of the policy.
3. **Appropriate Discharge**
    a. Once a patient has three no shows or cancellations, the patient should be notified that they will be discharged at this time, with guidance that they can return after 1 month (or once they are more available) with a new referral.
4. **Removal of Appointments**
    a. Once a patient has unexpectantly missed three consecutive appointments, all follow-up appointments should be removed from the schedule immediately.
5. **Specialty Exceptions**
    a. Internal Pelvic Heath and Neuro Policy
        i. Patients who come to Buffalo Rehab Group for internal pelvic health or neurologic services will be discharged after unexpectedly missing two consecutive appointments.

Patient History Form

Buffalo Rehab Group

Name: _____ Age: _____ DOB: _____

Primary Care Physician/Family Physician: _____

Leisure activities, including exercise routines: _____

Occupation: _____ Are you on a work restriction from your doctor? **YES** ☐ **NO** ☐

Do you smoke? **YES** ☐ **NO** ☐ Are you latex sensitive? **YES** ☐ **NO** ☐

Do you have a pacemaker? **YES** ☐ **NO** ☐ Please list any known allergies _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES** ☐ **NO** ☐

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ fatigue
- ☐ fever/chills/sweats
- ☐ nausea/vomiting
- ☐ weight loss/gain
- ☐ falls
- ☐ difficulty maintaining balance
- ☐ numbness or tingling
- ☐ muscle weakness
- ☐ dizziness/lightheadedness
- ☐ heartburn/indigestion
- ☐ diarrhea
- ☐ constipation
- ☐ changes in bowel/bladder function
- ☐ difficulty swallowing
- ☐ shortness of breath
- ☐ fainting
- ☐ cough
- ☐ headaches
- ☐ currently feeling down or hopeless

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Chemical dependency
- ☐ Depression
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Rheumatoid arthritis
- ☐ Other arthritic condition
- ☐ Bladder/urinary tract infection
- ☐ Sexually transmitted disease/HIV
- ☐ Incontinence
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Kidney problems
- ☐ Ulcers
- ☐ Liver problems
- ☐ Hepatitis
- ☐ Other: _____

Please list prior surgeries and date(s) _____

Date of injury/onset of current symptoms _____ Date of surgery_____

What do you think caused your symptoms?_____

Please check any of the following services that you are receiving currently:

Physical Therapy ☐ Occupational Therapy ☐ Chiropractic Care ☐ Massage Therapy ☐ Speech Therapy ☐

Have you had any of the following for your current problem: X-Ray ☐ Injection ☐ MRI ☐ CT Scan ☐ Other ☐ _____

Have you ever had this problem before? **YES** ☐ **NO** ☐ If yes, when? _____

In your current living environment: Do you have stairs? **YES** ☐ **NO** ☐ Do you live alone? **YES** ☐ **NO** ☐

How would you rate your overall quality of life? Excellent ☐ Good ☐ Fair ☐ Poor ☐

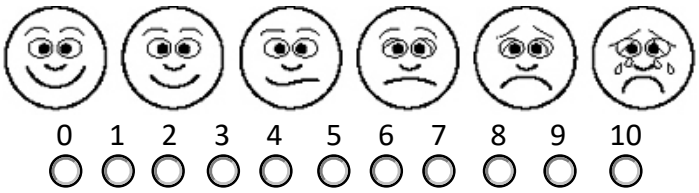
Please list 3 activities that you are unable to do or having difficulty with as a result of your problem.

1. _____
2. _____
3. _____

Name: _____ DOB:_____

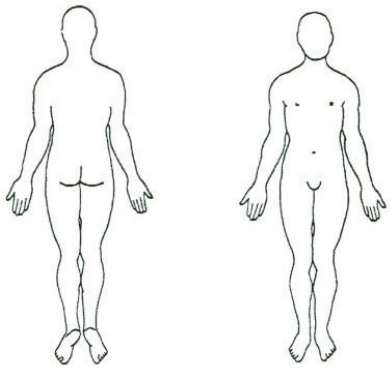
Pain Assessment:

Using the scale below, please select the **WORST** your pain has been during the **past 24 hours**.
0 = no pain, 10 = worst pain imaginable



0 1 2 3 4 5 6 7 8 9 10

On the chart to the right, please mark the areas where you feel PAIN with an "**O**" and NUMBNESS/TINGLING with an "**X**".



Back Front

Medication Assessment:
Please list any medications you are currently taking (including pills, injections, skin patches, vitamins, herbs, etc):

Medication Name	Dosage	Frequency	Route of Administration (select how you take this med)
			oral ☐ injection ☐ patch ☐
			oral ☐ injection ☐ patch ☐
			oral ☐ injection ☐ patch ☐
			oral ☐ injection ☐ patch ☐
			oral ☐ injection ☐ patch ☐
			oral ☐ injection ☐ patch ☐
			oral ☐ injection ☐ patch ☐
			oral ☐ injection ☐ patch ☐
			oral ☐ injection ☐ patch ☐

Next referring MD appointment: _____/_____/_____

Buffalo Rehab Group

NEW PATIENT INFORMATION FORM

(Please Print and write name how it is shown on your insurance card)

PATIENT INFORMATION

Patient's First name: MI: Last Name:				Date of Birth:
Social Security #:(not required but helpful for ins)		❑ Male ❑ Female		Patient Nickname:
Street address:				
City:	State	Zip Code	Preferred Contact no:	Email Address:
Occupation:	Emergency Contact Name			Emergency Contact phone no.:

Referred to clinic by (please check one box):
❑ Physician ❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Other _____

Referring Physician Name and Phone Number:	Primary Care Physician Name and Phone Number:

INSURANCE INFORMATION
(ALSO COMPLETE NEXT PAGE IF WORKERS COMP OR NO FAULT)

Primary Insurance Plan: (i.e. BCBS)		**Secondary Insurance Plan: (i.e. BCBS)**	
Insured's ID Number:		Insured's ID Number:	
Insured's Policy Group #:		Insured's Policy Group#:	
Insured's Name:		Insured Name:	
Insured's Date of Birth:		Insured's Date of Birth:	
Insured's Address:		Insured's Address:	
Insured's City:		Insured's City:	
Insured's State:		Insured's State:	
Insured's Zip Code:		Insured's Zip Code:	
Relation to Insured:		Relation to Insured:	
Insured's Gender:	M ☐ F ☐	Insured's Gender:	M ☐ F ☐
Insured's Employer:		Insured's Employer:	
Insured's Phone #:		Insured's Phone #:	

ACCIDENT DETAILS- PLEASE COMPLETE IF THIS VISIT IS DUE TO INJURY

Employment related: Y ☐ N ☐	Motor Vehicle Accident related: Y ☐ N ☐	Date of first symptom or accident:

Give details of accident and complete next page if accident related:

I authorize the release of any medical or other information necessary to process insurance claims.
I authorize payment of medical benefits directly to this practice for the services rendered.

Patient/Guardian signature Date

*By providing my e-mail address, I'm authorizing the clinic to send me appointment reminders via e-mail

Please fill out Page 2 if Worker's Compensation or No Fault Case

ONLY COMPLETE IF THIS IS A WORKER'S COMPENSATION OR NO FAULT CASE

Workers Comp Carrier Name:		**No Fault Insurance Name:**	
Insurance Company Address		Insurance Company Address	
Insurance Co City		Insurance Co City	
Insurance Co State		Insurance Co State	
Insurance Co Zip		Insurance Co Zip	
Carrier Case/Claim #		Carrier Case/Claim #	
WCB #		Policy #	
Case Manager Name		Policy Holder Name	
Case Manager Phone #		Adjuster Name	
Employer's Name		Adjuster Phone Number	

I refuse to provide this practice with my personal health insurance information. I am aware that if WC/No Fault denies payment, I am solely responsible for the remainder of the bills. _____Initials