Brazos Orthopedic Physical Therapy

Michael Timothy Ward, P.T.

Date _____

PATIENT REGISTRATION

Patient's Name _____ Date of Birth _____Sex: M F

Last First Middle

Address _____ City _____State _____ Zip _____

Telephone _____ Social Security Number _____ Referred by _____

Patienfs Employer _____ Address _____

Work Telephone Number _____ Email _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Social Security Number _____ Spouse's Work Telephone Number _____

Guarantor's Name _____ Date of Birth _____ S S Number _____

Address (if different above) _____ City _____ State ___ Zip _____

Guarantor's Employer _____Address _____ Phone _____

Nearest relative or contact person: Name _____ Address _____

City _____Telephone _____ Relationship to patient _____

INSURANCE INFORMATION - Please provide us with your insurance card(s) to copy for our records.

Medicare Number _____ Medicaid Number _____

Primary Insurance _____ Address _____

Insurance Telephone _____ Policy# _____ Group# _____

Insured's Name _____ Patient's relationship to insured ___ Self __ Spouse ___ Child ___ Other

Insured's Date of Birth _____Was condition related to employment? Y N Auto accident? Y N

Other accident? Y N Date of accident _____

Secondary Insurance _____ Address _____

Insurance Telephone _____ Policy# _____ Group# _____

Insured's Name _____Patient's relationship to insured ____Self __Spouse ____Child ___Other

Insured's Date of Birth _____

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE

I authorize the provider or insurance company to release any information required for this claim. I authorize my insurance benefits to be paid directly to Brazos Ortliopedic Physical Therapy, P.C. I understand that even though I have assigned benefits to be paid directly to Brazos Orthopedic Physical Therapy, P. C., I am still responsible for the entire bill.

Signed _____ Date _____

Brazos Orthopedic Physical Therapy

Michael Timothy Ward, P.T.

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the _____ Insurance Company to pay directly to Brazos Orthopedic Physical Therapy, P.C. benefits due me, if any, by reason of services described in the statement rendered and are provided for in the above policy contract with aforementioned Insurance Company. I will be responsible for all such charges incurred or for all charges in excess of whatever sum may be paid by the Insurance Company above mentioned. I authorize the release of any medical information necessary to process this claim.

MEDICARE PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INF PAYMENT REQUEST:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Brazos Orthopedic Physical Therapy, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date _____ Signature_____

Brazos Orthopedic Physical Therapy

Michael Timothy Ward, P.T.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this 0ffice's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Brazos Orthopedic Physical Therapy

Michael Timothy Ward, P.T.

AUTHORIZATION TO RELEASE RECORDS

Name _____ Date of Birth _____

Address _____

I, _____, authorize: Brazos Orthopedic Physical Therapy
Michael T. Ward, PT
2701 East 29“ Street
Bryan, TX 77802

To release medical information from my medical records (entire record if necessary) to:

Name of Doctor, Hospital, ect. _____

Address _____

City State, Zip Code _____

Name of Insurance Company _____

Address _____

City State, Zip Code _____

I understand that I have the right to revoke this authorization, except to the extent that action has been taken in reliance on this authorization.
Instructions on how to revoke this authorization: If you Wish to revoke this authorization, you must do so in writing to Brazos Orthopedic Physical Therapy at 2701 East 29th Street in Bryan, TX 77802.
I also understand that, when this information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the recipient.
This authorization will expire one year from the date of signature.

Please check one of the follow:

☐ You HAVE my permission to contact me at my work.

☐ You DO NOT HAVE my permission to contact me at my work.

_____ _____

Authorized Signature Date

_____

Relationship to Patient

Brazos Orthopedic Physical Therapy

Michael Timothy Ward, P.T.

Current Medications: (Please include any over the counter medications)

___ Presently I am not taking any medications
___ I have a list that you can copy and place in my Physical Therapy chart.

* You do not have to list the dosage amount.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Medication Allergies: _____ None _____ I have a list that you can copy.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medical History: (Please check all that pertain to you only)

___ I have a list that you can copy.

___ High blood pressure
___ Diabetes
___ Thyroid Disease
___ Seizure Disorders
___ Shortness of Breath
___ Cardiac Problems: (Please describe below)

_____
_____
_____

___ High blood pressure
___ Diabetes
___ Thyroid Disease
___ Seizure Disorders
___ Shortness of Breath
___ Other _____

_____
_____
_____

List Past Surgeries: (Give dates if you can)

_____
_____
_____
_____

2701 East 29"‘ Street, Bryan, Texas 77802 • O: (979)776-0247 • Fax: (979) 774-9515 • Toll Free: 1-866-776-0247