BRAZOS VALLEY REHABILITATION CENTER
1318 Memorial Drive
Bryan, Texas 77802
979-776-2872 Fax 979-776-1456

www.brazostherapy.org

BRAZOS VALLEY
REHABILITATION CENTER

Patient Registration Forms

PATIENT INFORMATION (PLEASE PRINT)

Patient's First Name | MI | Last Name | Gender (M / F) | Date of Birth | Age

Parent/Guardian Name | Relationship | Email Address

Use this phone number to send me automated text and call notifications | Work Phone #

Street Address* | City | State | Zip | County

Name of Insured | Relationship to Patient | Date of Birth | Employer Name

Insurance Company Name | Policy ID# | Group #

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ Cell: _____ Preferred Hospital: _____

MEDICAL RELEASE OF INFORMATION

I authorize the following person access to my medical records at the Brazos Valley Rehabilitation center:

Name/Relationship to patient | Name/Relationship to patient

For pediatric patients ONLY:

☐ **I do** give consent to the BVRC to access my child's medical and school records for therapeutic and assessment purposes.

☐ **I do not** give consent to the BVRC to access my child's medical or school records for therapeutic and assessment purposes.

SOCIAL SERVICES NOTICE

Every patient case is reviewed by our interdisciplinary team and screened for social services. Should we identify such a need, a referral will be made and an appointment with our social worker will be arranged. You may also request a meeting with our social worker if you believe you need assistance in areas described below:

- Assess the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care.
- Assess the relationship of the patient's medical and nursing requirements to his/her home situation, financial resources, and the community resources available upon discharge from therapy.
- Counsel and refer for casework assistance in resolving problems in these areas.

☐ **I do** wish to schedule an appointment with the social worker

☐ **I do not** wish to schedule an appointment with the social worker.

Staff Name (print) | Signature | Date

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CONSENT FORM

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of this agency, I authorize Brazos Valley Rehabilitation Center to:

1. Secure and retain medical treatment and transportation if needed,
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication(s) and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below cannot be reached.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I authorize the staff at Brazos Valley Rehabilitation Center to undertake such treatment and procedures as deemed appropriate to improve my condition. It is recognized that the practice of medicine is not an exact science and, as such, no guarantees are made by the staff of Brazos Valley Rehabilitation Center as to the results of treatment or interventions performed. I am advised that I have the full right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome of my treatment program may be affected. Persistent refusal to participate or cooperate in the recommended treatment program may result in my discharge from the program.

I consent to the use and/or disclosure of my protected health information by the Brazos Valley Rehabilitation Center (BVRC) for the purpose of the diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of BVRC. I understand that my diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. BVRC is not required to agree to the restrictions that I may request. However, if BVRC agrees to a restriction that I request, the restriction is binding on BVRC and its therapist.

I have the right to revoke the consent, in writing, at any time, except to the extent that BVRC has taken action in reliance on this consent.

ASSIGNMENT OF BENEFITS AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or other insurance carriers any information needed for this claim. I authorize this provider of therapy services to obtain pre-authorization and file for medical benefits due me under any medical insurance or government benefit plans for which I am eligible. I also authorize payment of any medical benefits due me directly to the above named provider of services for services or equipment, which they provided subsequent to this date.

STATEMENT OF FACT

This is to advise Medicare and /or Medicaid recipients and/or Private Insurance beneficiaries that there are certain services and equipment, which may not be covered as medical benefits under their program. There is the possibility that certain services and/or equipment as ordered by your physician may fall into the non-payment classification. Therefore, please be advised by this Statement of Fact, that if this is the case, you will be held responsible for payment of services/equipment not covered, as well as any coinsurance or deductible due. These amounts normally will be expected at the time of services.

Patient Name (print)	Signature	Date
Responsible Party Name (print)	Signature	Date
Staff Name (print)	Signature	Date

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I, the undersigned, hereby certify that I have read and understand the above. Furthermore, I personally guarantee full and timely payment for all services rendered. Payment for services rendered is required at time of service unless prior arrangements have been made.

PATIENT CONFIRMATION
I have granted permission (verbal or in writing) for BVRC to inquire as to the following benefits/services on the members behalf. I understand that any insurance verification is NOT A GUARANTEE OF PAYMENT. I am personally responsible for timely payment in full of all eligible services received at Brazos Valley Rehabilitation Center not covered or declined by my insurance carrier.

NOTICE OF PRIVACY PRACTICE

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review BVRC's Notice of Privacy Practices prior to signing this document. The Brazos Valley Rehabilitation Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of BVRC. The Notice of Privacy Practices for BVRC is also provided in the downstairs lobby. This Notice of Privacy Practices also describes my rights and the BVRC's duties with respect to my protected health information.

BVRC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

BVRC Policies

DROP OFF/PICK UP AUTHORIZED INDIVIDUALS (MINOR PATIENTS): Our patients' and staff safety is of paramount importance at BVRC. Any pediatric patient receiving services in the clinic MUST be dropped off and picked up by an AUTHORIZED representative. Patients will not be released to unauthorized individuals and will be picked up from the treatment area at the designated end of their appointment. I hereby authorize the following individuals to drop off/pick up:

Name_____Relationship to patient _____Telephone #_____
Address _____Driver's License/ID
_____

Name_____Relationship to patient _____Telephone #_____
Address _____Driver's License/ID
_____

_____ _____
Patient Name (print) Signature Date

_____ _____
Responsible Party Name (print) Signature Date

_____ _____
Staff Name (print) Signature Date

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ATTENDANCE POLICY: A PATIENT MUST ATTEND A MINIMUM OF 75% OF SCHEDULED APPOINTMENTS WITHIN A 2 MONTH PERIOD IN ORDER TO REMAIN AN ACTIVE PATIENT AT THIS FACILITY. However, **3 no-shows in a row will result in automatic discharge.**

In the event the patient's attendance falls below 75**%**, a warning letter will be given to the patient to allow them the opportunity to increase their attendance over the next month. If the patient's attendance does not increase over the next month, they will be discharged and will not be eligible to receive another initial evaluation at this facility for a period of 6 months. After such time, the admissions process will need to be restarted.

Should you be unable to attend an appointment, you must notify the facility AT LEAST 24 HOURS IN ADVANCE. Failure to do so will be considered a no show.

SMOKING POLICY: For the consideration and protection of our patients, staff and visitors, our facility does not allow Smoking or Vaping IN or ON premises. Signage has been posted to clearly indicate No Smoking is allowed. Compliance is mandatory.

PETS POLICY: For the consideration and protection of our patients, staff and visitors, our facility does not allow pets in our building. The exception to this rule applies only to "Certified Service Pets" on site for the purpose of therapy treatment.

Newsletter sign-up!

Would you like to receive our monthly newsletter and stay up-to-date with clinic activity?

☐ Yes, email me at:_____
☐ No, thank you!

THE FORMS ON THE FOLLOWING TWO PAGES ARE **OPTIONAL.**

_____	_____	_____
Patient Name (print)	Signature	Date
_____	_____	_____
Responsible Party Name (print)	Signature	Date
_____	_____	_____
Staff Name (print)	Signature	Date

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

RE:_____

DOB:_____

I,_____, on behalf of (circle one) myself or the above named person, authorize the Brazos Valley Rehabilitation Center to disclose to_____

The following information:_____

for the purpose of_____

Additional information/comments:_____

I, the undersigned, understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance hereon, without express revocation.

TO THE PARTY RECEIVING THIS INFORMATION: The information has been disclosed to you from records whose confidentiality is protected by the Federal Law. Federal Regulations (42CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person whom it pertains, or as otherwise permitted by such regulation. NOTE: A general authorization for the release of medical or other information is not sufficient for patient records protected under Federal Law 42, CFR, Part 2.

_____ _____
Signature of Patient **Date**

_____	_____	_____
Patient Name (print)	Signature	Date
_____	_____	_____
Responsible Party Name (print)	Signature	Date
_____	_____	_____
Staff Name (print)	Signature	Date

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_____ _____

Signature of Patient's Guardian, Authorized Representative or Parent **Date**

_____ _____

Witness **Date**

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

RE:_____

DOB:_____

I,_____**, on behalf of (circle one) myself or the above named person, authorize:**
[Holder of personal and health information address and phone number]_____
_____
_____
to disclose to:
[Recipient of personal and health information] **Brazos Valley Rehabilitation Center** **the following information:**_____
_____
for the purpose of (please include descriptors such as treatment, evaluation, consultation, etc)_____
_____

Additional information/comments:_____
_____

I, the undersigned, understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance hereon, without express revocation. I fur

_____ _____

_____ _____
Patient Name (print) Signature Date

_____ _____
Responsible Party Name (print) Signature Date

_____ _____
Staff Name (print) Signature Date

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Signature of Patient **Date**

_____ _____

Signature of Patient's Guardian, Authorized Representative or Parent **Date**

_____ _____

Witness **Date**

_____ _____

Patient Name (print) Signature Date

_____ _____

Responsible Party Name (print) Signature Date

_____ _____

Staff Name (print) Signature Date