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.

Patient Name (print) Patient/Responsible Party Signature Date

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

www.brazostherapy.org

BRAZOS VALLEY
REHABILITATION CENTER

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

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

www.brazostherapy.org

BRAZOS VALLEY
REHABILITATION CENTER

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_____License ID/_____

Name_____Relationship to patient_____Telephone #_____
Address_____License ID/_____

_____ _____ _____
Patient Name (print) Signature Date

_____ _____ _____
Responsible Party Name (print) Signature Date

_____ _____ _____
Staff Name (print) Signature Date

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

www.brazostherapy.org

BRAZOS VALLEY
REHABILITATION CENTER

Physical, Occupational and Speech Therapy Attendance Policy

Thank you for choosing Brazos Valley Rehabilitation Center to provide your child's therapy services. After your child's evaluation, your therapist will discuss your child's therapy plan and have you schedule follow-up appointments if needed. Regular attendance is important to promote progress toward his/her therapy goals. Here are a few important things for you to know.

Our promise to you:
If you arrive and check-in at least 10 minutes before your appointment time, we promise to start your therapy session within 5 minutes of the scheduled appointment time.

Your promise to us:
Your child's success depends on attending every therapy session and arriving on time. We ask that you cancel appointments as soon as you are aware you are not able to attend so those appointments can be used by other families. A minimum of 24 hours' notice is requested and greatly appreciated. Below are some ways to cancel your appointment:

• Call the therapy location directly. Our phones are answered 7:30am – 5:00pm Monday-Friday. 979-776-2872

• Email us: info@brazostherapy.org

• Reminder text message: You have the option to receive an automated text message appointment reminder. You can request to cancel your appointment from the text.

Cancel/No-Show Policy

• If you **miss 3 consecutive appointments** without notifying us prior to the appointment time **OR**

• If you **miss 5 consecutive appointments** with or without notification

Your therapy slot(s) on the schedule will no longer be reserved. We will invite you to schedule additional follow-up appointments one at a time. If we don't hear back from you within 60 days, your services will be discontinued. We would love to serve you in the future, should a need arise; however, a new prescription will be needed from your referring physician.

• If you arrive more than 15 minutes late for 3 consecutive appointments, your therapist will re-evaluate your timeslot. Options will be discussed in regards to different times, days, and/or possible discharge.

Thank you for helping us make your therapy a success. Our primary goal is to help your child in reaching their goals. Your participation and attendance are critical in the therapy success.

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!

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

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

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