PATIENT REGISTRATION FORM

NAME:_____ DATE:_____

DOB: _____ E-MAIL:_____

ADDRESS:_____CITY, STATE, ZIP:_____

PHONE: _____ □ HOME □WORK □CELL

PHONE: _____ □ HOME □WORK □CELL

SOCIAL SECURITY #:_____MARITAL STATUS:_____

SEX: □ MALE □ FEMALE

EMPLOYER:_____PHONE:_____

ADDRESS:_____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP:_____

PHONE:_____

INSURANCE INFORMATION:

INSURANCE:_____

ADDRESS:_____

NAME OF INSURED:_____RELATIONSHIP:_____

DOB OF INSURED:_____ SEX: □ MALE □ FEMALE

GUARANTOR:_____ □ SAME AS PATIENT

RELATIONSHIP:_____ DOB:_____

SOCIAL SECURITY#:_____

BRIDLEWOOD FAMILY HEALTHCARE P.A.
PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

DATE:_____ LAST PHYSICAL EXAM:_____
LAST NAME:_____FIRST NAME:_____
DOB:_____ SEX:_____ AGE:_____ MARITAL STATUS:_____
OCCUPATION:_____ ETHNICITY:_____
Due to patient confidentiality, information contained here will NOT be released to anyone without your written authorization.

MEDICAL HISTORY: (*High Blood Pressure, Diabetes, Asthma, Cancer, Heart disease, Etc*.)

_____

_____

_____

_____

_____

SURGICAL: (*Tonsillectomy, Appendectomy, Hysterectomy, Hernia, Etc*.)

_____

_____

_____

ALLERGIES □ NONE (If YES, please list medications and explain type of reaction i.e. hives, wheezing, upset stomach, swelling, etc.)

_____

CURRENT PRESCRIPTION MEDICATION:
Name of drug, mg dose, #tablets, # times per day

_____

_____

_____

_____

Use back side (if needed)

OTC MEDICATION: (Aspirin, Tylenol, Aleve Vitamins, Herbals)

_____

_____

_____

_____

_____

Use back side (if needed)

FAMILY HISTORY

Father: □ Living, age:_____ □ Deceased, age at death:_____ (Cause) _____
Mother: □ Living, age:_____ □ Deceased, age at death:_____ (Cause) _____
Siblings: Number living:_____ Number deceased:_____ (Cause)_____

List other illnesses in your family (example: Diabetes, Heart disease, Colon Cancer, Breast Cancer, Prostate Cancer, etc.)

FAMILY MEMBER	ILLNESS
_____	_____
_____	_____

SOCIAL HISTORY

SMOKE? □ YES / □ NO If yes, how much?_____ # of packs/day _____ # of years When did you stop smoking?_____
ALCOHOL? □ YES / □ NO If yes, how much?_____

Exercise regularly? □ YES / □ NO If yes, what and how frequently? _____
Routinely wear seatbelts? □ YES / □ NO Routinely wear a helmet? □ YES / □ NO Substance Abuse? □ YES / □ NO

PATIENT/PARENT SIGNATURE:_____

BRIDLEWOOD FAMILY HEALTHCARE

FINANCIAL POLICY

At Bridlewood Family Healthcare, we help you to coordinate your medical expenses by filing to most major insurance plans. We are unable to quote specific coverage. All coverage is specific to the plan you selected through your employer or broker. To fully understand your individual insurance policy, it is your responsibility to contact your insurance to discuss your benefits. To assist you with understanding your financial responsibility with us, please see below:

****Attention: Please check each box below****

□ You are required to provide a copy of all insurance plans that you currently have and a photo ID.

□ If a copay is required for your policy, it is due at the time services are rendered.

□ If your insurance should change, it is your responsibility to provide updated information for your account. Failure to timely provide this information may make us unable to bill your insurance for your visit and the charges will be your responsibility.

□ We utilize LabCorp for our lab services. According to your insurance plan, you may receive a bill from the lab based on the benefits that you selected. You must contact your insurance company/lab company to discuss your bill.

□ Services and procedures are coded and billed based on what the provider has determined medically necessary. Your individual insurance plan will process your claims based on the benefits that you have selected.

□ we may order diagnostic services such as x-rays, scans, and MRIs to assist with your medical care. It is your responsibility to know your policy coverage for those services.

□ for cash pay patients, or if your deductible has not been met, the entire amount is due when services are rendered unless an agreement has been pre-approved by the Practice Manager.

□ failure to provide all insurance coverage information is considered to be fraudulent and may result in services not being rendered or dismissal from the practice.

Policy/Claim Information:

1. Your insurance is a contract between you and your employer/insurance company.
2. It is possible that your insurance may not cover all the services that are rendered. It is your responsibility to know your policy limitations.
3. All coding will be done based on the services rendered and by the national coding guidelines. Codes will not be modified to fit a certain category of benefits.
4. In the event that you have a balance after your insurance has paid, it is your responsibility to make arrangements to pay the balance due. We do follow general collection guidelines.

PLEASE READ THE ABOVE CAREFULL BEFORE SIGNING. By signing below, I acknowledge that I have read, understand, and accept this policy.

Print Name: _____ Date of Birth:_____
Signature: _____ Date:_____

ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Bridlewood Family Healthcare for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information

I hereby authorize Bridlewood Family Healthcare to (1) release any information necessary to insurance carriers regarding my illness and/or treatments: (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Bridlewood Family Healthcare on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____

Patient Name

FINANCIAL POLICY/PAYMENT PLAN POLICY

Deductibles

If you have a deductible, you will be held responsible for the amount your insurance allows for your visit. If you are unable to pay this amount in full you must pay at least $100.00 at the time of service.
We will not take payment during your annual wellness visit. Please note that if you have diagnostic services or testing done at the same time as your annual wellness visit they may be subject to your deductible.

Large Balances

If your balance exceeds $100, you must pay at least ½ of your balance within the first 30 days it becomes due. Additionally, you will need to set up a payment plan with our office regarding the remaining balance due.

Payment Plans

If you have a payment plan on file you will be responsible for contacting the office with any changes. If your credit card is declined at any time there will be an additional $25.00 fee.

Other

If your insurance does not pay for any reason, you will be responsible for the entire balance. If you do not pay a balance after 90 days you will be subject to further collection actions and possible dismissal from our practice.

_____ _____

Patient/Parent Signature Date

_____

Patient Name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this office'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 your Notice of Privacy Practices.

_____	_____
Print Patient Name	Patient Signature
_____	_____
Parent/Guardian Signature (if Minor)	Date

NOTICE OF FINANCIAL INTEREST

I have been informed that my physician Dr. Brian D. Glaser has a financial interest in the following healthcare facilities:

Texas Health Presbyterian Hospital Flower Mound
Flower Mound, TX
(469) 322-7000

I understand that my Physician may refer me to the facility listed above or any other healthcare facility of my choice.

I acknowledge that I have read this Notice of Financial Interest and have been able to ask questions and receive answers regarding it.

_____	_____
Patient (Guardian) Signature	Date