New Patient Registration Form - Bradley D. Powell, PhD

2400 Broadmoor * Suite C * Bryan, TX 77802 * Ph (979) 774-9255 * Fax (979) 774-9299

PATIENT INFORMATION (please print clearly)

Patient's Name	Marital Status S M W D Sep	Sex M F	Age	Date of Birth	Social Security #
Mailing Address	City and State		Zip Code		Home Phone #
Patient's Employer (or school)	Occupation				Business Phone #
Employer's Street Address	City and State		Zip Code		Other Phone #
Emergency contact (not living with you)	Relationship				Phone #
E-mail address (for appointment reminders):					
Who referred you to this practice?	Who is your Family physician/PCP?				

IF THE PATIENT IS NOT THE INSURED:

Responsible party's name	Marital Status S M W D Sep	Sex M F	Date of Birth	Social Security #
Mailing Address	City and State		Zip Code	Home Phone #
Employer	Occupation			Business Phone #
Employer's Street Address	City and State		Zip Code	Relationship to patient

PRIMARY INSURANCE

Name of insurance company	Phone # (to verify benefits)		Phone # (for precertification)
Street Address	City and State	Zip Code	Name of the insured
ID#	Group #		Group Name (or employer name)

SECONDARY INSURANCE

Name of insurance company	Phone # (to verify benefits)		Phone # (for precertification)
Street Address	City and State	Zip Code	Name of the insured
ID#	Group #		Group Name (or employer name)

RELEASE OF INFORMATION

Due to HIPAA privacy laws we are not permitted to give out any behavioral health information without the patients written consent. If there is anyone you would like us to be able to share your information with, please put their name on the line below.

I hereby authorize the following individual _____ (ex. Family, spouse, friend) access to my personal behavioral health records. I understand I may revoke this authorization at any time and must communicate this to my doctor.

Patient or Guardian Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS:

I hereby authorize Bradley D. Powell, Ph.D. to furnish appropriate and necessary details of medical and psychological information to my insurance company.

I hereby authorize payment of medical and psychological benefits to Bradley D. Powell, Ph.D. for services rendered.

I give my permission to Bradley D. Powell, Ph.D. to provide psychological services to the patient listed above.

Patient Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

(if patient is a minor)