74 Regency Parkway, Mansfield, TX 76063 • Phone: (817) 345-6225 • Fax: (817) 701-4902

NEW PATIENT PACKET - WELCOME TO REGENCY CARDIAC REHAB

What is the reason for your visit today?

How did you hear about us? (please specify)

☐ Website/Advertisement ☐ Physician Referral: _____
☐ Friend / Family ☐ Other: _____

Patient Information

Name (First, Middle, Last) | Social Security # | Date of Birth | ☐ Male ☐ Female

Mailing Address | Apt # | City, State, Zip

Email Address | Primary Phone | ☐ Home ☐ Cell | Okay to call? Okay to text? ☐ Call ☐ Text

Occupation / Employer (or parent/guardian employer if patient is a minor) | Work Phone

Primary Care Provider (where you go for your routine medical care)

Preferred Language

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Partner

Contact Preference ☐ Home ☐ Mobile ☐ Email ☐ Portal ☐ Mail

Emergency Contact

Contact Name | Phone Number | Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last) | Social Security # | Date of Birth

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name | Policy Number/Member ID | Group Number

Policy Holder | Date of Birth | Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent

Claim# / Adjustor | Phone

Secondary Medical Insurance (if applicable)

SECONDARY Insurance Company Name | Policy Number/Member ID | Group Number

Policy Holder | Date of Birth | Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent

Claim# / Adjustor | Phone

Attorney | **Contact** | **Phone**

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FINANCIAL AGREEMENT

I hereby instruct and direct my health insurance company, personal injury protection insurance company, and/or my attorney to pay by check, made out and mailed to Regency Pain & Therapy Institute, for healthcare services allowed and otherwise payable to me, under my current insurance policy, as payment toward the total charges for the professional services rendered by this office.

I agree that I am financially responsible for all charges incurred at this office; including any insurance deductible, co-pays, or services not covered by my insurance company, workers compensation, and/or my attorney.

I hereby acknowledge and agree to the following:

- A $35.00 fee will be assessed for returned checks.
- If copies of your medical records are needed, the first copy will be free of charge. For any additional copies required, there is a $35 fee per copy.
- We require a 24-hour notification should you be unable to keep your scheduled appointment for any type of office visit or procedure. Failure to do so could result in a no-show fee of $35.
- As a courtesy, we will call, email or text to remind you of your appointment one day in advance. However, you are still responsible for the appointment, even if we are unable to contact you. We understand that unforeseen events can occur such as illness or emergencies, but kindly give us a call if you're unable to keep your appointment time.
- Payment is required prior to or at time of service.
- Failure to pay could result in cancellation of appointment until payment can be rendered.

Signature _____ Date _____

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NOTICE & ACKNOWLEDGEMENT

Authorization of Release of Protected Health Information to Family Members

I authorize Regency Pain & Therapy Institute to release protected health information to my family member(s) listed below:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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MEDICAL HISTORY FORM

Name _____ DOB _____ Age _____ ☐ Male ☐ Female

Medications Currently Taking (Please include all prescription, over-the-counter, vitamins, and supplements)

NAME OF MEDICATION	DOSAGE OF MEDICATION

Allergies to any medications, x-ray dyes or other substance? ☐ Yes ☐ No
(If yes, please list name of medication and any type of reaction)

_____

_____

Surgeries/Hospitalizations

DATE	DETAILS

Severe Injuries

DATE	DETAILS