Wayne Physical Medicine & Rehabilitation Associates

401 Hamburg Turnpike, Suite 105
Wayne, NJ 07470

PLEASE FILL OUT THIS SHEET COMPLETELY AND CORRECTLY.
PLEASE PROVIDE ALL INSURANCE CARDS TO THE RECEPTIONIST TO COPY.

Name _____ Social Security # _____

Address _____ City, State & Zip Code _____

Home Phone No. ( ) _____ Cell Phone No. ( ) _____

Date _____ Marital Status _____ Sex Male___ Female ___ Date of Birth _____

Patient's Employer _____ Work Phone No. ( ) _____

Occupation _____ May we call you there? ____ Yes ____ No

Insurance Co. _____ ID # _____ Group No. _____

Secondary Insurance Co. _____ ID # _____ Group # _____

If you are covered by someone else's insurance, what is the relationship?

Spouse ____ Parent _____ Guardian _____ Their Date of Birth _____ SS# _____

Their Name _____ Phone No. ( ) _____

Their Employer _____ Work Phone No. ( ) _____

Insurance Co. _____ ID # _____ Group # _____

Any Known Drug Allergies? _____

Who referred you to our office? _____

In the event of an emergency, who should we contact?

Name _____ Phone No. ( ) _____

Relationship _____ Work Phone No. ( ) _____

I authorize the release of any information including medical records, diagnosis and treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay Wayne Physical Medicine & Rehabilitation Associates. I understand that I am fully responsible for all non-covered services as well as any balances not paid by my insurance carrier. I will agree to abide by all policies and procedures as set for by the physician and my insurance carrier; failure to do this will result in dismissal from this medical practice.

Signature of Patient or Guardian _____ Date _____

Wayne Physical Medicine & Rehabilitation Associates
401 Hamburg Turnpike, Suite 105
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Ph# (973) 595-6066 Fax# (973) 595-1127

PLEASE PROVIDE US WITH A LIST OF YOUR CURRENT MEDICATIONS THAT YOU ARE TAKING:

_____

_____

_____

PAST MEDICAL & SURGICAL HISTORY:

_____

_____

_____

ALLERGIES:

_____

_____

_____

Signature_____ Date_____

WAYNE PHYSICAL MEDICINE & REHABILITATION ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Our notice of privacy practices provides information about how we may use and disclose protected health information ("PHI") about you
You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may
change. If we change our Notice, you may obtain a revised copy by contacting Wayne Physical Medicine & Rehabilitation Associates.

You have the right to request that we restrict how your PHI is used or disclosed for treatment, payment or health care operations.
We are not required to agree to this restriction, but if we do, we are bound by this agreement.

By signing this patient acknowledgement form, you are hereby acknowledging that you have received our Notice of Privacy Practices.

_____ _____

Patient Name Patient Signature

_____ _____

Name of Witness Witness Signature

_____

Date

Wayne Physical Medicine & Rehabilitation Associates

Please be advised that you are responsible for your co-payment and insurance deductible. Please discuss with the office representative any payment arrangement that you may need. It is, also your responsibility to let the receptionist know if there are any changes on your insurance policy within 7 days. Also be advised of our "**Tardiness Policy".**

Tardiness Policy
At Wayne Physical Medicine & Rehabilitation Associates we are committed to giving the best possible individual care. For this to happen, it is important to keep your scheduled appointment. Arriving late for an appointment may necessitate rescheduling or treatment by an alternative provider.

Patient Signature: _____ Date: _____

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Appointment Cancellation Policy

At Wayne Physical Medicine & Rehabilitation Associates, patients are scheduled for treatment at appointment times that are convenient for the patient and established by the patient with the office management. In order for our therapists to provide quality care and individualized attention, dedicated treatment times are established with patients prior to a scheduled session. When an appointment is made, that time block is reserved and no other patient can be substituted. Patients are responsible for their scheduled appointments and if they cannot attend a particular appointment must call within 24 hours prior to the scheduled appointment. If the office is closed, patients may leave a message with the answering service. If no prior notification is made by the patient within 24 hours prior to a scheduled appointment, a $ 50.00 fee will be billed to the patient. (please note that your insurance carrier is not responsible for this fee)

I hereby have read and understand the above stated policy.

_____ _____

Patient Signature Date