

1

Patient Information

First Name: _____ Last Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Date of Birth: ____ / ____ / _____ Age: _____
 Height: _____ Weight: _____ Male Female
 Social Security #: _____ - _____ - _____
 Occupation: _____
 Employer: _____
 Employer Address: _____

 Guardian's Name (if minor): _____
 Single Married Divorced Widowed Separated
 Spouse's Name: _____
 Referred by: _____

2

Insurance

Who is responsible for this account? _____
 Relationship to patient: _____
 Insurance company: _____
 Insurance employer: _____
 Insurance ID number: _____
 Group/Claim Number: _____
 Are you covered by additional insurance? Yes No
 Insurance company: _____
 Insurance ID number: _____
 Group/Claim Number: _____
 Birthdate of insured: _____

Please present insurance card(s) so we may obtain a copy on file

3

Accident Information

Is your condition due to an accident? Yes No
 Date: ____ / ____ / _____
 Type of accident? Automobile Work Slip-and-Fall
 Who have you reported the accident to? Insurance Co.
 Worker's Comp Employer Other: _____
 Attorney Name (if applicable): _____

4

Contact Information

Home #: _____
 Mobile #: _____ *Provider: _____
* To generate text reminders
 Work #: _____ Ext: _____
 Email: _____
 Best way to reach you: Home Cell Work Email
EMERGENCY CONTACT
 Name: _____ Relationship: _____
 Home #: _____ Cell #: _____

5

Patient Condition

What is your major symptom(s)/problem(s)? _____

When did your symptoms begin? _____

Have you had this problem before? Yes No

Is your condition getting worse? Yes No

Is this problem: Constant Comes and Goes

Describe your pain (mark all that apply)

Burning Sharp Shooting Dull Aching Stiffness

Tingling Throbbing Swelling Other: _____

CIRCLE below the severity of your pain on a scale of 1-10

(No pain) **1 2 3 4 5 6 7 8 9 10** (Severe pain)

What makes your condition better? _____

What makes your condition worse? _____

When are you in most pain? Morning Afternoon Evening While sleeping Constantly

Does it interfere with your... Work Sleep Daily Routine Recreation Exercise Routine

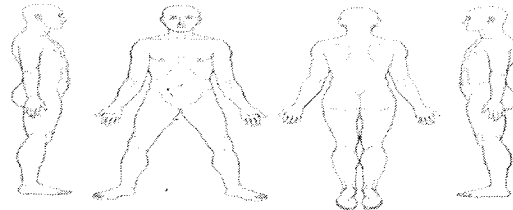
Activities/movements that are painful to perform:

Sitting Standing Walking Bending Lying down Driving Reading Getting up

**How often do you experience your symptoms?
Indicate where you have pain or other symptoms?**

Constantly (76-100% of the day)
 Frequently (51-75% of the day)
 Occasionally (26-50% of the day)
 Intermittently (0-25% of the day)

Please mark with an X below where you feel pain:





175 Washington Ave.
Dumont, NJ 07621
spinalrehab175@yahoo.com
P: 201-384-3300
F: 201-384-2745

Patient Informed Consent and Responsibilities

I understand that I am a patient of Spinal Rehabilitation and Wellness Center, a multidisciplinary facility that encompasses chiropractic care, physical therapy rehabilitation and acupuncture treatments. My care is the exclusive responsibility of the practitioners of Spinal Rehabilitation and Wellness Center as well as any other practitioners who also may practice at this location.

Cooperation with treatment:

For treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my physician.

No warranty:

I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of treatment have been explained to me. The physicians at the facility provide a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

● Chiropractic Care

- The doctor will use his/her hands or mechanical device in order to move your spinal joints. This procedure is called a spinal adjustment and it is intended to reduce spinal subluxations. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. You may feel a "click" or "pop", and you may feel movement of the joint. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. Various ancillary procedures, such as electrical stimulation, ultrasound, mechanical traction, manual therapeutic massage of the musculature, or hot/cold packs may be used.

● Physical/Occupational Therapy Care

- The care services provided manage a wide variety of conditions. The purpose of therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. Response to therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Spinal Rehabilitation and Wellness Center does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the treatment may result in aggravation of existing symptoms and may cause pain or injury.

● IDD Therapy®

- IDD Therapy® (Intervertebral Differential Dynamics Therapy) provides computer-directed mechanical traction to the lumbar and/or cervical intervertebral discs and facet joints. IDD Therapy® protocols allow for the controlled manipulation and distraction of targeted intervertebral discs to mobilize the joint and create a negative pressure inside the intervertebral disc. This negative pressure leads to the diffusion of fluid and nutrients into the disc to stimulate its metabolism and promote hydration and healing. The negative pressure can also lead to the

retraction of a herniated nucleus pulposus. IDD Therapy® treatment further delivers a passive exercise element to release spasmodic behavior and to re-educate supporting soft tissues. Spinal Rehabilitation and Wellness Center does not guarantee what your reaction will be to IDD Therapy®, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. There is a possibility that IDD Therapy® may result in aggravation of existing symptoms and may cause pain or injury.

- PEMF

- PEMF is a safe, non-invasive FDA cleared modality for the treatment of pain and temporary increase in microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. PEMF utilizes visible and invisible laser radiation; therefore, appropriate eye protection is required at all times during treatment. Individuals respond uniquely to treatment. Results may be immediate after the first treatment or depending on the severity of the condition it may require several treatments before results are seen. Increased soreness may occur after the first laser session. This is a normal healing phenomenon known as retracing. Failing to complete any part of the treatment program will reduce the chances of success. Spinal Rehabilitation and Wellness Center does not guarantee what your reaction will be to laser therapy, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. There is a possibility that laser therapy may result in aggravation of existing symptoms and may cause pain or injury.

Potential risks:

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physician. Additionally, I understand that there are some risks to treatment. While rare, these risks include but are not limited to fractures, disc injuries, strokes, and sprains. The risks of injuries or complication from treatment are substantially lower than that associated with many medical or other treatments, medication, and procedures given for the same conditions, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her is in my best interest. The risks of complications due to treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can even be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

Potential benefits:

I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives:

If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physical therapist, as well as my physician or primary care provider. I have read the above information, and I consent to evaluation and treatment.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known are in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read or have had read to me the explanation above of care that is available to me within Spinal Rehabilitation and Wellness Center. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the health plan recommended to me and hereby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek.

Patient Name (Please Print)

Patient or Legal Guardian Signature

Date



175 Washington Ave.
Dumont, NJ 07621
spinalrehab175@yahoo.com
P: 201-384-3300
F: 201-384-2745

State of New Jersey – Department of Human Services Notice of Privacy Practices

Effective Date April 14, 2003

***** Please Note: YOUR BENEFITS OR ELIGIBILITY WILL NOT BE AFFECTED BY THIS NOTICE *****

This notice applies to individuals, or legal guardians or parents of minor children receiving services from the Department of Human Services.

Protected health information excludes individually identifiable health information in Education Records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

OUR RESPONSIBILITIES: The Department of Human Services is required by law to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.

In addition, the Department of Human Services is required to:

- Abide by the terms of this notice
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Notify you if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our privacy practices change, we will provide you with a revised notice.

GENERAL PRIVACY RULE

We will not use or disclose your health information without your written authorization, except as described in this notice.

Revoking Your Authorization: If you provide us with a written authorization to release your health information, you may revoke that authorization at any time. A revocation must be in writing. A written revocation will not revoke your prior authorization if we have already released information pursuant to your prior authorization or if your insurance coverage requires your written authorization.

Separate Authorization for Psychotherapy Notes: We will not release any psychotherapy notes about you without a separate written authorization from you. You may revoke your specific written authorization at any time. A revocation must be in writing. A written revocation will not revoke your prior authorization if we have already released information pursuant to your prior authorization or if your insurance coverage requires your written authorization.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. **Treatment.** We may use your health information for your treatment. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and may be used to determine your diagnosis or the course of treatment that should work best for you. A doctor or other health care professional may share your information

with other health care professionals who are either part of the Department of Human Services or who are outside of the Department of Human Services to determine how to diagnose or treat you.

2. **Payment.** We may use your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
3. **Health care operations.** We may use your health information for regular health operations. For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.
4. **Business Associates.** There are some services provided in our organization through contracts with business associates. Examples include our accountants, consultants and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require that the business associates appropriately safeguard your information.
5. **Facility Directory.** If you do not object, we may include your name, location within our facility, and general condition in our facility directory while you are at the facility. This information would only be disclosed to people who ask for you by name. In addition, unless you object, we may include your religious affiliation to disclose only to clergy members and will disclose that information even if the clergy member does not ask for you by name.
6. **Family and Friends Involved in Your Care.** If you do not object, we may share your health information with a family member, a relative or close personal friend who is involved in your care or payment related to your care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us to notify those persons.
7. **Research.** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
8. **Funeral directors.** We may disclose health information to funeral directors and coroners to carry out their duties consistent with applicable law.
9. **Organ procurement organizations.** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking of organs, or transplantation of organs for the purpose of tissue donation and transplant.
10. **Contacts.** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
11. **Food and Drug Administration (FDA).** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.
12. **Workers compensation.** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
13. **Public Health.** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
14. **Correctional institution.** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
15. **Law enforcement.** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
16. **Abuse, Neglect or Domestic Violence.** We may disclose your health information to the extent provided by law to an authority, social service agency or protective services agency if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will notify you of this disclosure promptly unless it would place you at risk of serious harm.
17. **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law such as audits, civil administrative or criminal investigations, inspections, licensure or disciplinary actions, or other activities necessary for oversight of the health care system, government benefit programs, government regulated programs, or compliance with civil rights laws.
18. **Judicial and Administrative Proceedings.** We may disclose your health information in response to an order of a court or administrative tribunal, or in response to a valid subpoena if we receive satisfactory assurances from the party seeking the information that the party has made an attempt to notify you or to secure a protective order for your information.

19. **National Security and Intelligence Activities.** We may disclose your health information to authorized federal officials for national security activities.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the Department of Human Services, the information in your health record belongs to you. You have the following rights:

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, the Department’s general health care operations, and/or to a particular family member, other relative or close personal friend. We ask that such requests be made in writing to the privacy officer. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it.
- You have the right to receive confidential communications of your health information. If you are dissatisfied with the manner in which or location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing and submitted to the privacy officer. We will accommodate all reasonable requests.
- You may request to inspect and/or obtain copies of health information about you, which will be provided to you within 30 days. Such requests must be made in writing to the privacy officer. If you request to receive a copy, you may be charged a reasonable fee.
- If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. You must provide a reason to support your request. Such requests must be made in writing to the privacy officer.
- You may request that we provide you with a written accounting of all disclosures made by us of your health information for up to a six-year period of time; however, disclosures made prior to April 14, 2003, do not have to be accounted for by law. We ask that such requests be made in writing to the privacy officer. Please note that an accounting will not include the following types of disclosures: disclosures made for treatment, payment or health care operations; disclosures made to you or your legal representative, or any other individual involved with your care; disclosures authorized by you or your legal representative; disclosures to correctional institutions or law enforcement officials or for national security purposes; disclosures made from the directory; and disclosures that are incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by). There is no charge for the first request for an accounting made in any twelve-month period, but there may be a reasonable charge for additional requests in the same twelve-month period.
- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.
- You may revoke any authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing to the privacy officer.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the appropriate privacy officer listed on the attached sheets.

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing to the Department’s Privacy Officer. The complaint form may be obtained from the Department’s Privacy Officer and when completed should be returned to State of New Jersey, Department of Human Services PO Box 700, Trenton, NJ 08625. You may also file a complaint with the Secretary of the federal Department of Health and Human Services by writing to 200 Independence Avenue SW, Washington DC 20201. This needs to be done within 180 days of when the problem happened. You can also complain to the Office of Civil Rights by calling 866-627-7748.

If you make a complaint to the Department’s Privacy Officer or to the Secretary of Health and Human Services, there will be no retaliation against you and your benefits will not be affected.

Patient Name (Please Print)

Patient or Legal Guardian Signature

Date



175 Washington Ave.
 Dumont, NJ 07621
 spinalrehab175@yahoo.com
 P: 201-384-3300
 F: 201-384-2745

Agreement to Forward Payment

This letter is to inform you that in most cases BC/BS does not send payments to the physician directly. As the patient, you will be receiving payments for services rendered at our offices. When this occurs, we find that it is easiest to endorse the **back of the checks, and simply mail or bring them in with you on your next visit along with the explanations of benefits.** This will allow us to refrain from asking you for payment when services are rendered. Please do not cash the checks you receive for services provided by our office. We are then in the uncomfortable position of asking for payment months later, after hours on the phone to the insurance company tracking where the payments have been sent.

BC/BS also posts "PAID" payments to our billing service that they have paid. If this occurs our billing company, **Precision Billing**, will send you a letter that you have received a check. If you have not received the check then please call **Precision Billing** at (201)501-8500, and they will in turn set up a conference call with BC/BS to resolve the situation.

For your convenience, Spinal Rehabilitation and Wellness Center is asking that our BC/BS patients provide a credit card to keep on file. This information will only be utilized if an outstanding balance is incurred from receiving and not remitting BC/BS checks that you receive.

Thank you for your patience in this matter, as these are BC/BS policies not our own.

I, _____, am aware that my insurance company may send me payments for services rendered by Spinal Rehabilitation and Wellness Center, which may include a consultation, physical therapy exam / treatment, chiropractic exam / treatment, acupuncture exam / treatment, etc. These are insurance phrases that include the treatment that you receive when you are at our office. If you have any questions regarding these charges, please do not hesitate to inquire at the front desk upon your next visit.

By completing this form, you agree that when you receive any payments for those services, you will:

1. Sign the check and **not deposit or cash it**
2. Under your signature print the following:
"Make Payable Only to Spinal Rehabilitation and Wellness Center"
3. Enclose the check with all accompanying letters or forms, such as the Explanation or Benefits, in an envelope, and mail immediately to Dr. Peter Ferraro at the address on this letterhead.

Additionally, by completing this form, you understand that in the event that the check is not immediately sent to Dr. Esposito, you will be responsible to pay the full and entire fee for all of the services rendered, plus 12% interest on any additional collection fees and legal costs in connection with collecting this debt.

Spinal Rehabilitation and Wellness Center and/or Dr. Esposito is hereby given Power of Attorney to endorse/sign your name on any and all checks for payment of your doctor's bill; only in connection with services provided by Spinal Rehabilitation and Wellness Center and/or Dr. Esposito.

A copy of this agreement can be provided to you as a reminder of what is required when you receive the payment from your insurance company.

_____ Patient Name (Please Print)	_____ Patient Signature	_____ Date
_____ Credit Card Number	_____ Date of Expiration	_____ CCV



175 Washington Ave.
Dumont, NJ 07621
spinalrehab175@yahoo.com
P: 201-384-3300
F: 201-384-2745

Assignment of Benefits/E.R.I.S.A. Authorization Form Spinal Rehabilitation and Wellness Center

Patient Name (Please Print): _____

Employer (of Policyholder): _____

SSN/ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

(name of insurance company)

Spinal Rehabilitation and Wellness Center
175 Washington Ave.
Dumont, NJ 07628

If my current policy prohibits direct payment to my doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

Spinal Rehabilitation and Wellness Center
175 Washington Ave.
Dumont, NJ 07628

My health insurance benefits have been explained to me. I am aware that Spinal Rehabilitation and Wellness Center is a non-participating facility and is subject to my deductible and coinsurance.

Financial Responsibility

I have requested professional services from Spinal Rehabilitation and Wellness Center ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I hereby authorize Provider to submit claims on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and 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. This order will remain in effect until revoked by me in writing.

Attorney Representation and Protection of Balance

I hereby request my attorney to pay any outstanding bills out of my settlement and in effect, protect any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Signature of Policyholder

Patient Signature

Date



175 Washington Ave.
Dumont, NJ 07621
spinalrehab175@yahoo.com
P: 201-384-3300
F: 201-384-2745

No-Show, Late, & Cancellation Policy

Cancellation/No Show Policy:

All treatments in chiropractic, physical therapy, acupuncture, nutrition and specialty doctors require 24 hour notice for the cancellation of a scheduled appointment. There is a \$50 charge for a no-show or cancellation without proper notice. This charge will not be covered by your insurance. We understand that extenuating circumstances may occur which is why we have implemented a "three-strike" policy. We will allow for three cancellations before charging a fee. For every cancellation or no-show beyond three, a \$20 fee will be assessed. Maintaining regular treatment sessions is essential for positive outcomes. Repeated cancellations and/or no shows will hinder your care and may result in discharge from our facility.

Lateness Policy:

It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or later time. We will be happy to honor your request if other appointment times are available, however; simply arriving late or early changes the course of treatment for yourself and others. We cannot guarantee that we will be able to treat you if you are more than 15 minutes late for an appointment. Similarly, you may be asked to wait until your scheduled appointment time if you arrive more than 10 minutes early for your appointment. In order to provide you with the best possible care, we ask that you arrive at the time of your appointment.

We take these policies seriously because when a patient misses an appointment, three people are adversely affected:

1. You, the patient — for not receiving the treatment you need
2. Your provider — as now he or she has a gap in the schedule
3. Another patient — who could have had your appointment time

Certain accident claims adjusters expect regular attendance to treatments as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having pain or not having pain are NOT reasons to cancel or fail to show for your scheduled treatment. If you are in pain, it is important to come in because there are treatments available and/or program modifications that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your course of treatment to correct the underlying causes of your injury which will prevent future setbacks.

I consent to the above, as indicated by my signature below:

Print Name

Signature

Date