

Robert Wood Johnson University Hospital Somerset

**RWJBarnabas
HEALTH**

Welcome

Thank you for choosing the RWJBH Somerset Sports Physical Therapy to assist you in your recovery.

We ask that you arrive 15 minutes early and have the completed attached paperwork. Otherwise you will need to arrive 40 minutes prior to scheduled evaluation time.

As a courtesy, we will call your insurance company and confirm your physical therapy benefits although it is the patient's responsibility to understand his/her insurance specific coverage and we suggest you also call prior to your visit. Any questions please feel free to call us. The RWJBH Somerset's facility identification number is 1003236878 or Medicare ID 310048 and or tax ID 221487243

To facilitate registration process, please arrive 15 minutes prior to your first scheduled appointment with the following:

- Current signed prescription from your doctor
- Enclosed paperwork filled out and signed
- Valid photo ID (such as Driver's license, county ID, etc.)
- Your medical insurance cards
- Any referrals that may be required by your insurance company
- Any applicable co pays or co-insurance if required (we accept cash, check, most credit cards) payment is required at time of service.
- A list of all your current medications
- Sneakers or good support shoes (**NO flip flop open toe shoes/ sandals**), any braces or assistive device your doctor has prescribed.
- Loose fitting clothing, (shorts and a T shirt are a good choice) that will allow full freedom of movement
- Locker rooms and showers are available if you need to change
- Enclose are directions to our facility
- Remember to pick up parking pass on your way out (this is to be displayed on dashboard of vehicle)

The staff of Sports Performance and rehab Center is striving to provide outstanding care and service. If at any time during the course of your rehabilitation process, you have any recommendations, please do not hesitate to let us know. The best time to address your concerns is while you are here. Please call the rehab center with any questions at **908-203-5972 opt 1**

Sincerely,

The Staff at RWJUH Sports Physical Therapy Bridgewater Ballpark
1 Patriot Park
Bridgewater NJ 08807
908-203-5972 Fax 908-685-2413

RWJUH/Sports Physical Therapy
Website: www.rwjbh.org/sportspt

DIRECTIONS TO RWJBH SPORTS PHYSICAL THERAPY & PERFORMANCE CENTER

The Sports Physical Therapy & Performance Center is located at TD Bank Ballpark, 1 Patriots Park, in Bridgewater, NJ.

From Route 287 North

Take Exit 13B (Somerville / Route 28 West). Once on Route 28 West, turn left at the 2nd traffic light (Foothill Road / Chimney Rock Road). At the next traffic light, turn left onto East Main Street. TD Bank Ballpark will be on your right. Go through the 1st traffic light and make your 1st right immediately past the Ballpark onto Cole drive. Parking is in the lot on your right.

From Route 287 South

Take Exit 13 (Route 28). At the end of the exit ramp, turn right onto Route 28 West. Turn left at the 1st traffic light (Foothill Road / Chimney Rock Road). At the next traffic light, turn left onto East Main Street. TD Bank Ballpark will be on your right. Go through the 1st traffic light and make your 1st right immediately past the Ballpark onto Cole drive. Parking is in the lot on your right.

From Route 22 East

Turn right onto Chimney Rock Road. At 2nd traffic light, turn left onto East Main Street. TD Bank Ballpark will be on your right. Go through the 1st traffic light and make your 1st right immediately past the Ballpark onto Cole drive. Parking is in the lot on your right.

From Route 22 West

Take exit on right for Thompson Avenue / Bound Brook / Martinsville (The Office Restaurant on corner). Take 1st left for Route 22 East / Bound Brook. Follow overpass over Route 22. Bear right at end of overpass towards Bound Brook onto Thompson Avenue. At 1st traffic light, turn right onto Route 28 West / Union Avenue. Turn left at 4th traffic light (Foothill Road / Chimney Rock Road). At the next traffic light, turn left onto East Main Street. TD Bank Ballpark will be on your right. Go through the 1st traffic light and make your 1st right immediately past the Ballpark onto Cole drive. Parking is in the lot on your right.

From Route 78 (East and West)

Take Exit 29 (Route 287 South / Somerville). Once on Route 287 South, take Exit 13 (Route 28). At the end of the exit ramp, turn right onto Route 28 West. Turn left at the 1st traffic light (Foothill Road / Chimney Rock Road). At the next traffic light, turn left onto East Main Street. TD Bank Ballpark will be on your right. Go through the 1st traffic light and make your 1st right immediately past the Ballpark onto Cole drive. Parking is in the lot on your right.

From Somerville Circle

Follow signs for Route 22 East and follow directions above.

By Train

On New Jersey Transit, the Raritan Valley line stops at TD Bank Ballpark.

**Robert Wood Johnson | RWJBarnabas
University Hospital HEALTH
Somerset**

Sports Physical Therapy

PARKING PERMIT

ONE TIME ONLY

908-203-5972 opt 1

Issued by Donna Wildgen

Please display in windshield when attending program

When using ball park rehab or WHITE parking lot

Please remember to pick up new parking pass after your initial evaluation, as these changes monthly

Date:		Birthplace:		Race:	
Smoker: Y / N		Primary Language:		Previous Patient: Y / N	
Email Address:					
Have you traveled to West Africa (Guinea, Liberia, Sierra Leone and Nigeria) in the last 21 days? Y / N					
If Yes, have you had a fever in the last 24 hours? Y / N					
PATIENT INFORMATION					
Last Name:			First Name:		
Street Address:		City:		State:	Zip Code:
County:	Phone:			Cell:	
	Can we leave a message? Y / N			Can we leave a message? Y / N	
DOB:	SS#:	Sex: M / F		Marital Status: (Single / Married / Divorced / Widowed / Separated)	
Living Will: Y / N	Employment Status: FullTime / Part Time / Self / Student / Not employed / Retired				
Employer Name:			Occupation:		
Auto Related: Y / N If yes, State: _____		Work Related: Y / N	Date of Injury/Accident:	Adjustor/Claim Rep. Name & Phone#	
Work Comp/MVA Insurance Co.:			Work Comp/MVA Claim#		
Have you had PT this year: Y N			# of visits: _____	Have you treated for this condition previously: Y N	
PRIMARY INSURANCE INFORMATION					
Name of Insurance Company:					
Policy Holder's Name:		Relation:		DOB:	M / F
Address:			Phone:		
SECONDARY INSURANCE INFORMATION					
Name of Insurance Company:					
Policy Holder's Name:		Relation:		DOB:	M / F
Address:			Phone:		
EMERGENCY CONTACT INFORMATION					
Emergency Contact:		Relation:		Phone:	

Robert Wood Johnson University Hospital Somerset

RWJBarnabas
HEALTH

T. D. Bank Ballpark
Ph: (908) 203-5972 opt 1

One Patriot Park
Fax: (908) 685-2413

Bridgewater, N.J. 08807
RWJUH Somerset Tax ID: 22-148-7243

REHABILITATION ATTENDANCE POLICY

To Our Patients:

It is important that those who need our services are able to begin treatment as soon as possible. In addition, insurance companies closely monitor attendance to ensure consistent compliance with therapy prior to reimbursement. *While most importantly, non-compliance or frequent cancellations will limit the benefits of therapy it can also jeopardize insurance coverage.* Therefore, RWJUH Somerset Sports Performance and Rehabilitation Center has the following attendance policy:

1. If a patient fails to keep two consecutive appointments without notification, they will be discontinued from program and a new prescription will be required to return. Frequent cancellation can undermine the patient's progress and can be cause for discharge.
2. At the discretion of the Physical Therapist, if a patient is more than 10 minutes late for a scheduled appointment without notification, the patient can be denied treatment until the next scheduled appointment.
3. We have verified your benefits as a courtesy to you. Since everyone's plan is different and we are often misquoted benefits, we **encourage you to contact your insurance company directly.** We are an outpatient physical therapy facility under the name **Robert Wood Johnson Barnabas Health (RWJBH)** national provider ID is 1003236878 or tax ID is 221487243

Remember, this time is reserved for you. We want to be fair as well as accommodate all who need our services. Please take full advantage of the time allotted for you and do not jeopardize your coverage.

Thank you in advance for your cooperation and your commitment to your physical therapy program.

Signature

Date

Name: _____

Date: _____

Date of Birth: _____

Sports Physical Therapy & Performance Center • One Patriot Park • (908)203-5972 • Fax (908) 685-2413

Welcome to Sports Physical Therapy. Please assist us in filling out the following personal history

Gender: Male Female neither Male nor Female Other Transgender Female to Male Transgender Male to Female

Occupation _____ Physician _____ Follow up appointment: _____

Date of injury or most recent episode of pain; _____ Date of Past Surgery; _____

Briefly describe how you injury occurred: _____

Have you has any previous or similar problems? _____

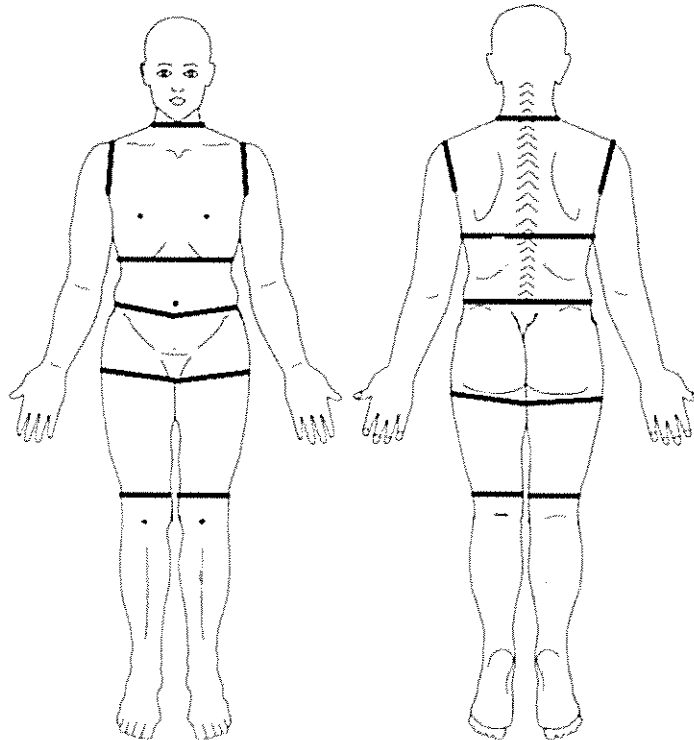
What activities aggravate your symptoms? _____

What eases your symptoms? _____

In the diagram below, please circle involved areas of the body and check all options that apply

Chief Complaint:

- Pain
- Soreness
- Swelling
- Stiffness
- Locking
- Instability
- Weakness
- Numbness / Tingling



Type of pain:

- Sharp
- Burning
- Spasm
- Dull
- Radiating
- Achy
- Numbness/Tingling

Duration of Pain:

- Constant
- Intermittent
- During rest
- During activity
- Following activity
- Night pain

Rate you current level of Pain

- 1 No pain
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 worst

Are you currently under another physician/healthcare's at this time?

Medical Doctor MD	Chiropractor	Athletic trainer
Doctor of Osteopathy DO	Psychiatrist/ Psychologist	Other
Podiatrist	Acupuncturist	
Physical Therapist	Massage Therapist	

Are you a smoker? YES NO _____ packs

Do you drink alcohol? YES NO

If yes, how many days per week do you drink alcohol? _____

How many drinks do you have during an average day? _____ Allergic to latex Yes No

Please list any allergies: _____

Have you had any of the following tests for THIS condition (Please write yes or no and answer as completely as possible)

TESTS	YES	NO	DATE	RESULTS
X-rays				
MRI				
Bone Scan				
CAT scan				
EMG/NCV				
Other				

During the past 2 weeks, have you taken any of the following over the counter medication? If so please circle all that apply

Aspirin	Antacids	Tylenol
Advil ibuprofen Motrin	Decongestants	Vitamins
Antihistamines	Herbal medications	other

Please list any prescription medication that you are currently taking. You may attach a separate list if you prefer.

Have you presently suffer with any of the following conditions? Please circle

Anemia	Diabetes (insulin)	Heart Disease	Osteoporosis
Asthma	Dizziness	Hepatitis	Parkinson'
Blood Clot	Emphysema	HIV	Pregnant or possibility
Cancer	Epilepsy	High Cholesterol	Rheumatoid Arthritis
Chemical Dependency	Falls	Kidney Disease	Stomach Ulcers
Circulator problems	Fibromyalgia	Lyme's Disease	Stroke
Concussion	Headaches- Migraines	Multiple Sclerosis	Thyroid (Hyper / Hypo)
Depression	Head Injury (recent)	Osteoarthritis	Tuberculosis
Other	Other	Other	Other

Have you recently experience any of the following? Please Circle

Fever/ Chills/ Sweats	Bowel/ Urinary Problems	Weakness	Night pain/ loss of sleep
Unexplained weight loss / gain	Vision Problems	Numbness or Tingling	Coordination / balance
Nausea / Vomiting	Facial Numbness	Shortness of breath	Difficulty swallowing
Difficulty Speaking			

Any significant family history? _____



New Jersey Department of Banking and Insurance
**CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION
MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF
CLAIMS**

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.¹ This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

**CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF
INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS**

I, , by marking (or) and signing below, agree to:

- representation by Robert Wood Johnson University Hospital in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:25-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.
- release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____ Time: _____

Relationship to Patient: I am the Patient I am the Personal Representative (provide contact information on back)

¹ If the patient is a minor

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

GENERAL CONSENT

1. **CONSENT TO CARE:** I request and authorize RWJUH SOMERSET, the Hospital and its employees, attending physician(s) and such associates, assistants and/or residents as may be selected by the said physician(s), and all the persons caring for me, and to provide such medical care and to administer such routine diagnostic, radiological and/or therapeutic procedures and treatment including, but not limited to, the administration of pharmaceutical products, and intravenous medication, as in the judgment of the above persons deem necessary or advisable in my diagnosis, care and treatment. I am aware that the practice of medicine and surgery is not an exact science and I understand that no guarantee or assurance of beneficial results has been promised or implied as a result of the above-mentioned diagnostic and therapeutic procedures. I certify that I have read and fully understand this consent for diagnostic and/or therapeutic procedures and treatment. I understand that it may be necessary for my healthcare providers to take photographs, film and record and/or take other like images for medical, educational and other continuity of care purposes. [INSERT FOR TEACHING HOSPITALS: I understand that the Hospital is a teaching hospital, medical students, interns and/or residents may participate in my care and treatment.] I understand that no guarantees have been made to me about the outcome of this care.

Please initial here _____ . This consent for treatment will remain in effect and apply to all outpatient services through the end of the calendar year.

2. **MATERNITY DIVISION:** If I am admitted to have a baby (ies), this consent shall also apply to the admission and Hospital treatment of the baby (ies) who is/are delivered by me during this hospitalization.
3. **RECURRING VISITS/MULTIPLE TREATMENTS:** I understand that many conditions being treated will require multiple treatments or therapy sessions to obtain the desired results. These include radiation therapy, respiratory therapy, physical therapy, occupational therapy, speech pathology, home health visits, kidney dialysis treatments, cardiac rehabilitation services, wound care and psychological services. In the event that there is a change to the course of treatment, I understand that I will be required to execute a new consent form for such change in treatment. If, during this period, any of my registration information changes, i.e. address, phone, employment, insurance, guarantor, etc., I will notify the department where the registration originated of the change.
4. **PERSONAL VALUABLES:** I have been informed to send all valuables home. I understand that if I choose to keep any valuables at the Hospital not deposited for safekeeping, the Hospital will be released from all responsibilities in the event of the loss of my personal property such as eyeglasses, dentures, artificial devices, contact lenses, hearing aids, money or any other items. I hereby certify that I have been advised and fully understand that the Hospital and its employees are not responsible for any and all personal articles, clothing or cash that I retain in my possession or on my person while a patient in the hospital. I acknowledge being advised not to retain cash and to deposit valuables in excess of that amount for safekeeping with the hospital Security Department.
5. **RELEASE OF INFORMATION:** I understand that my patient information is kept in both hard copy and electronic form and that physicians and persons involved in my care have access to both forms of records. The Hospital may access electronic information about me from pharmacies I use, including prescriptions to treat AIDS/HIV, mental health issues, substance abuse and sexually transmitted diseases, if applicable. The pharmacy information will become part of my hospital medical record. I understand that if I do not wish the Hospital to access my pharmacy information, I must submit a written request to the Hospital's Privacy Officer. The Hospital also participates in electronic health information exchanges (HIEs) with various other health care providers. I authorize the Hospital and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to 'opt-out' of having my information shared through HIEs and instructions on how to do that can be found in the Notice of Privacy Practices, or may be requested from the Hospital's Privacy Officer. The Hospital may seek, release and verify all or part of my medical and/or financial records to any person, corporation, or government agency which is or may be liable under a statute, regulation, or contract to me, the hospital, my family member, or my employer, for all or part of the Hospital's charges.

I grant permission and consent to the Hospital, its assignees, all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, and third party collection agents (1) to contact me by phone at any number associated with me including wireless cell numbers, (2) to leave answering machine and voicemail messages for me and include in any such messages, information required by law (including debt collection laws) and/ or regarding amounts owed by me (3) to send me text messages or emails using any email addresses I provide and; (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services and my account. I HAVE CHECKED ALL DEMOGRAPHIC INFORMATION [attached] AND IT IS ACCURATE.

6. **AUTHORIZATION FOR TESTING:** In the event that any healthcare provider or first responder (including emergency medical service workers and police officers) involved in my care is exposed to my blood or bodily fluids and makes a request for testing and results of such testing, I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not

GENERAL CONSENT

limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I understand and agree that the results of the blood test shall be released to me, the healthcare provider/first responder exposed to my blood or bodily fluids. To the extent possible, these results will be provided to the healthcare provider/first responder without disclosing my name.

7. **DISPOSAL OF SPECIMENS:** I authorize the Hospital to dispose of all specimens and tissues taken for laboratory or pathology examination as well as all equipment and devices removed from my body (such as artificial joints, pacemakers, etc.).
8. **FINANCIAL AGREEMENT:** For and in consideration of services rendered, I agree to make prompt payment to the Hospital when billed for any and all charges not covered by valid insurance benefits. I understand that I am responsible for any health insurance deductibles, co-payments, and/or co-insurance. If I am classified as a self-pay patient, a deposit will be requested. I realize it is my obligation to obtain a referral, pre-certification or a second opinion should it be required prior to services. I understand that the hospital will not deny emergent or urgent treatment and/or admission based on my, or the patient's ability to pay. If the Hospital, or my insurance carrier, or its intermediaries, or the Quality Improvement Organization deems that medical and/or professional services to be given or already given are not medically necessary and/or are on-covered services; I must pay for those services deemed to be a patient responsibility.

PRE-CERTIFICATION: I acknowledge that precertification requirements have all been met: Yes No

9. **APPEALS:** BY MY SIGNATURE BELOW, I HEREBY CONSENT TO THE HOSPITAL ACTING ON MY BEHALF, DISCUSSING WITH OR APPEALING TO MY GOVERNMENT OR COMMERCIAL INSURANCE, ITS MEDICAL DIRECTOR AND/OR ITS PHYSICIAN DESIGNEE OR OTHERWISE TAKING ACTIONS WITH RESPECT TO ANY UTILIZATION MANAGEMENT, PAYMENT, OBLIGATORY OR OTHER DETERMINATION MADE CONCERNING THE PROFESSIONAL MEDICAL SERVICES PROVIDED OR TO BE PROVIDED TO ME BY THE HOSPITAL AND ITS PROFESSIONAL STAFF, IN ACCORDANCE WITH MY INSURANCE'S INFORMAL (STAGE I) AND FORMAL (STAGE II) APPEALS PROCESS AND APPLICABLE LAW. I CONSENT TO THE HOSPITAL PURSUING SUCH APPEALS ON MY BEHALF, HOWEVER, I RECOGNIZE THAT THE HOSPITAL HAS NO OBLIGATION TO PURSUE SUCH APPEALS. I understand that the Hospital will not deny emergent or urgent treatment and/or admission based on my, or the patient's inability to pay.
10. **AUTHORIZATION OF PAYMENT OF INSURANCE BENEFITS:** In consideration of the medical and/or physician services furnished to the patient by the Hospital and/or its authorized representatives, the undersigned patient, guarantor or policy holder, hereby assign all rights, title, and interest in any health care insurance policy, as it pertains to these medical and/or physician services to the Hospital. I authorize and request payment directly to the Hospital of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers, self-funded employer plans, or others who are financially liable for my medical care and treatment to cover the costs of care and treatment, including for health insurance benefits payable under terms of my policy or self-funded welfare benefit plan. I hereby authorize the release of any/all medical records about me for the purposes of payment of the services rendered to me.
11. **FINANCIAL ASSISTANCE:** I have received a copy of the notice of Financial Assistance and reduced Charge Financial Assistance. I understand I may be eligible for Hospital Care Payment Assistance or other forms of financial assistance but must apply to receive it.
12. **MEDICARE AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST:** I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that direct payment or authorized benefits be made on my behalf. I assign benefits payable for physicians' services to the physician or organization furnishing the services or authorize such a physician or organization to submit a claim to Medicare for payment. THE SERVICE I RECEIVE MAY NOT BE COVERED BY MY MEDICARE INSURANCE. IN THIS EVENT, I WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.
13. **DESIGNATED CAREGIVER:** I understand I will have the opportunity to designate at least one (1) caregiver after I have entered the Hospital and prior to my discharge. If I do choose to designate a caregiver, I understand that the Hospital will request my written consent to release my medical information to the designated caregiver in accordance with privacy laws, including HIPAA. I also understand that if I do not provide this written consent, the Hospital will not give my caregiver notice of my discharge plan.
14. **[New Jersey Department of Health (IMM-32) Consent to Participate Form for the New Jersey Immunization Information System (NJIIS):** I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history. I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26 4-131 et seq. and rules at N.J.A.C. 8:57-3. There is no cost to participate in this program. I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH Vaccine Preventable Disease Program may be contacted at website or telephone number listed below: P.O. Box 369, Trenton, NJ 08625-0369, Phone (609) 826-4860, Fax: (609) 826-4866. www.njiis.nj.gov]

Yes, I would like to participate in this program. No, I do not want to participate in this program.

GENERAL CONSENT

15. ADVANCE DIRECTIVE:

I have an Advance Directive/Living Will/Health Care Agent [] YES [] NO [] UNKNOWN

I am providing a copy to: _____

By my signature below, I acknowledge that I am in receipt of the Advance Directive Information.

Patient Signature/Authorized Representative

Relationship

Date/Time: _____

Acknowledgment Form

- * I acknowledge receipt of the Hospital's Privacy Notice. I received this notice at [x] Today's visit [] Prior visit
* I acknowledge receipt of the "Important Message from TRICARE". My signature only acknowledges my receipt of this message and does not waive any of my rights to request a review.
* I acknowledge receipt of the Patient's Bill of Rights.
* I understand that if I do not comply with the pre-certification/authorization requirements, I will be responsible for hospital charges.

I have read this form, my questions have been answered, and I understand and agree to its content.

Patient Signature/Authorized Representative

Relationship

The Patient is unable to sign because:

Witness to signature only.

Date/Time _____

Patient refused to sign the Acknowledgment form.

Date: _____

Reason _____

Signature of Hospital Representative

Title



COMMUNICATION ASSESSMENT

In order to assure that the services that are provided to you (or to the patient that you are legally responsible for) are not compromised by ineffective communication, we ask that you complete this form so that we can assess your communication needs and preferences. Kindly check each appropriate item.

I have no special communication needs

1. Deaf and Hard of Hearing

- I require the use of TDD/TTY
 - I require the use of an amplified telephone receiver
 - I require a closed caption television
 - I prefer written notes for brief communication
 - I prefer written notes for all communication
 - I prefer to lip-read and speak for myself for brief communications
 - I prefer to lip-read and speak for myself for all communications
 - I require a qualified sign language interpreter (at no cost to me)
- Other (please specify) _____



2. Visually Impaired/Blind

I require assistance with printed materials Other (please specify) _____

3. Non-English Speaking

- I require a translator in my language for communication. My language is: _____
- I request that any of the individuals below serve as my translator:
 Name: _____ Telephone Number: _____
 Name: _____ Telephone Number: _____

4. Special Needs Assistance For special needs assistance, contact the Patient Satisfaction department at ext. 42177 or Nursing Administration. For TDD/TTY contact the Operator.

I have read this form or have had it read to me.

Signature of Patient or person authorized to sign for patient _____ Date/Time: _____

Relationship to Patient: _____

Patient is unable to sign because: _____

Interpreter signature, if applicable: _____ Registrar electronic signature: _____

REFUSAL OF SERVICES OFFERED

- Patient declined sign language interpreter
- Patient declined other auxiliary aids and services offered

Patient: _____ Date/Time: _____

Witness: _____
Electronic Signature