



WASHINGTON WELLNESS CENTER

Acknowledgment and Understanding

It is the policy of Washington Wellness Center to provide service to all persons without regard to race, color, national origin, handicap/disability or age in compliance with 45 C.F.R. Parts 80, 84, and 91, respectively. The same requirements are applied to all, and there is no distinction in eligibility for, or in the manner of providing services. All services are available without distinction to all program participants regardless of race, color, national origin, handicap/disability or age. The person designated to coordinate compliance with Section 504 of Rehabilitation Act of 1973 non-discrimination against the handicapped/disabled) is Dr. Swanekamp, who can be reached at 609-426-1700.

PAYMENT AUTHORIZATION

I hereby authorize payment of benefits by my insurance company/companies directly to Washington Wellness Center. I understand that I am directly and full responsible to Washington Wellness Center for all bills incurred by me for health care services rendered to me which may not be paid by my insurance carrier.

Furthermore, I hereby authorize Washington Wellness Center to disclose, make available and furnish all information, records, reports or copies thereof relating to my examination, consultation and/or treatment and do permit inspection and copies or abstracts thereof to my health insurance carrier. I release the therapists, agents, employee's and any personnel acting on behalf of Washington Wellness Center from any and all liability whatsoever pertaining to any use of these records. A photocopy of this form will be valid as the original form.

Patient Signature _____ Date _____

WORKER'S COMPENSATION RELEASE

I hereby request and authorize Washington Wellness Center, to disclose, make available and furnish to

Company Name

or his/her authorized representative all information, records, x-rays, reports or copies thereof relating to my examination, consultation or treatment and do permit him/her to inspect and make copies or abstracts thereof. I release the therapists, agents, employee's and any personnel acting on behalf of Washington Wellness Center from any and all liability whatsoever pertaining to any use of these records. A photocopy of this form will be valid as the original form.

Patient Signature _____ Date _____

TREATMENT CONSENT

I hereby authorize Washington Wellness Center to render health care/physical therapy treatments to

- Myself Son Daughter

as recommended by Dr. _____

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Witness _____



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Confidential Patient Information

GENERAL INFORMATION

Patient Name _____ Entrance (Today's) Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone () _____ Work Phone () _____
 Date of Birth _____ Age _____ Sex Male Female
 Marital Status _____ No. of Children _____ SS# _____
 Employer _____ Occupation _____
 Onset Date of Current Symptoms or Accident Date _____
 If your discomforts are resultant from an accident, do you have an attorney representing you? Yes No
 If yes, name? _____ Phone () _____

INSURANCE INFORMATION

Health Insurance Carrier

Insurance Carrier _____ ID# _____
 Subscriber _____ Subscriber's Date of Birth _____

Other Health Insurance Carrier (eg. Spouse, parent, relative, etc.)

Insurance Carrier _____ ID# _____
 Subscriber _____ Subscriber's Date of Birth _____
 Subscriber's Employer _____

Motor Vehicle Accident Information (if applicable)

Insurance Carrier _____ Policy # _____
 Subscriber _____ Subscriber's Date of Birth _____
 Driver's License # _____ State _____
 Have you reported your accident to your insurance carrier? Yes No Claim # _____

WORK RELATED INJURY

Have you reported your accident to your employer? Yes No
 Supervisor's Name _____ Supervisor's Phone # _____
 Facility Location _____

LIABILITY INJURY

Place of Injury _____
 Was injury reported? Yes No If yes, to whom? _____