ROBERT D. BOYD, D.O.
WOODBRIDGE MEDICAL GROUP, P.A.

270 Main Street
Woodbridge, N.J. 07095-1927
(732) 636-5252
Fax (732) 636-5452

Patient Information

Patient Name | Prefix | Suffix

Maiden | DOB | Sex | SSN | Race | Ethnicity

Marital Status | Primary Language

Address Information

Address

City/State/Zip | County | Country
United States

Phone:
Home | Work | Cell | Primary

Email

Preferred Method of Communication

Emergency Contacts

Name
Phone
Relationship

Name
Phone
Relationship

Preferred Pharmacy Name | Address | City, State | Phone

MEDICARE

Name of Beneficiary _____ HI Claim Number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.**

I understand I am financially responsible for any balance not covered by my insurance carrier. **I will be responible for 100% of the cost of any collection and / or legal fees incurred by Woodbridge Medical Group, P.A.**

Signature X_____

A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

PLEASE PRESENT DRIVER'S LICENSE CARD AND INSURANCE ID CARD TO FRONT DESK ON COMPLETION OF THIS FORM

WOODBRIDGE MEDICAL GROUP, P.A.
MAIN STREET PHYSICAL THERAPY
ROBERT D. BOYD, D.O.
270 Main Street
Woodbridge, New Jersey 07095
Tele: (732) 636-5252 Fax: (732) 636-5452

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

I. Acknowledgement of Privacy Notice

I have received a copy of WOODBRIDGE MEDICAL GROUP, P.A./MAIN STREET PHYSICAL THERAPY/ROBERT D. BOYD, D.O. (WMG/MSPT/Dr. Boyd) Notice of Privacy Practices.

Patient's Name	Date of Birth	Signature of Patient	Date
_____	_____	_____	_____

II. I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone _____
- ☐ OK to leave message w/ detailed information
- ☐ Leave message w/ call back number only

☐ Written Communication
- ☐ OK to mail to home address
- ☐ OK to mail to work/office
- ☐ OK to fax to _____

☐ Work Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Other _____

III. Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that WMG/MSPT/Dr. Boyd may disclose certain of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, WMG/MSPT/Dr. Boyd will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of WMG/MSPT/Dr. Boyd making the limited disclosures described above. (I understand that I am not required to list anyone and that I may change this list at any time in writing.)

Print Name of Designated Person	Last 4 digits of his/her SS# or Date of Birth
_____	_____
_____	_____
_____	_____

_____ Signature of Patient

_____ Date

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INFORMATION FOR ALL NEW PATIENTS

Please be aware that we will be asking for your photo ID and Insurance Card on every visit

We would like to take your picture to be attached to your medical profile

Co-payment is expected upfront on every visit with the doctor

The front desk receptionist cannot accept any paperwork to be filled out by the doctor, **NO EXCEPTIONS**. An appointment must be made in order for paperwork to be filled out by the doctor in the room with you

Balances past due such as co-payment or deductible are expected to be taken care of during your visit to our office

Medications may not be refilled if you are overdue for your visit with the doctor

Please note that there is a **$25.00 FEE** for all no shows

Please be aware that it is your responsibility to make sure your insurance has **active coverage** on the day of your visit

We recommend you bring all of your medication bottles or a list of all your medications with the strengths and dosing to every office visit.

Please show the Medical Assistant any forms that you need to be filled out at the beginning of your visit

Please always bring a pen with you whenever you have an office visit

Always be a good listener

Thank you.

Dr. Robert D. Boyd

Rev. Dec 7, 2014

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
USES AND DISCLOSURES – PLEASE READ THIS CAREFULLY AND IN IS ENTIRETY

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professions who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. You are required to provide this practice with all insurance coverage information, health, auto and workers compensation (if applicable), or discuss and provide an alternative method for providing payment for services to this practice.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of this practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies; without your permission, to support government audits and inspections to facilitate law enforcement investigations and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

OTHER USES/ DISCLOSURES REQUIRING YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use of disclosure of you information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that has occurred prior to the date of your notify us.

APPOINTMENT REMINDERS: Your health information will be used by our staff appointment reminders.

INFORMATION ABOUT TREATMENTS: Your health information may be used to send your information on the treatment and management of your medical condition that you may find to be of interest. We may also send your information describing other health-related goods and services that we believe may interest or be of benefit to you.

INDIVIDUAL RIGHTS:
You have certain rights under the federal privacy standards: These include

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections of your protected health information
- The right to receive and obtain an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

THE DUTIES OF THIS MEDICAL PRACTICE
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also required to abide by the privacy polices and practices that are outlined in this notice

As permitted by law, we reserve the right to amend to modify our privacy polices and practice. These changes in our polices and practices may be required by changes in federal and state law and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will apply to all protected health information that we maintain.

REQUEST TO INSPECT INFORMATION: as permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access by asking our receptionist or by contacting the Privacy Officer in writing.

COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, or suspect violations, you may do so by letter, outlining the concerns. Please address correspondence to the Privacy Officer, c/o this medical practice at our current address.

THE EFFECTIVE DATE OF THIS NOTICE – DECEMBER 5, 2014