



To help RMA protect your privacy please provide the following information:

Patient Information (Please Print):

Patient Legal Name: _____ Date of Birth: _____
(First) (Middle Initial) (Last) (mm/dd/yy)

Marital Status: Widowed Single Divorced Married Spouse Full Name: _____

I agree to allow Rehabilitation Medicine Associates physicians and staff to discuss general medical information (this does not include HIV/AIDS related records, mental health information, drug/alcohol treatment or genetic testing) regarding my health with my spouse, significant other, other family member or caregiver listed below or leave a message at my home.

We leave reminder calls and appointment related information at your home number. We have a service that leaves a recorded message either with a person or an answering machine. You must let our office know if you do not want calls made to your home. Remember: You are financially responsible for missed appointments. Thank you.

Rehabilitation Medicine Associates may make reminder calls to my home. Yes No

Indicate the names of the people that we may use to communicate with you. Be specific and please print.

- Spouse/Children _____
- Significant Other _____
- Other Family Member/Members _____
- Caregiver _____
- Other _____
- Patient Comments _____

I have read and understand the information above. (Please sign at time of your appointment and in presence of RMA staff.)

Patient Signature _____ Date _____

Witness (RMA Clinic Personnel) _____ Date _____