

Phone (845)623-6566

Northeast Rehabilitation, Inc.
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Patient Express Registration

Today's Date: _____

Patient Info IMPORTANT: Please Fill-Out This Form Completely & Legibly (Do not leave any items blank)

Full Name _____ Age _____ Gender: M ___ F ___

Street Address _____

City _____ State _____ Zip _____

Home Phone () _____ Cellular () _____

Email(optional) _____

Emergency Contact Person _____ Ph _____

Do you authorize Northeast Rehabilitation Inc. to share your information with your emergency contact as pursuant to our privacy policy? ___ Yes ___ No

Is there another individual that you would like to share your information with pursuant to our privacy policy?
___ No ___ Yes Please contact: _____

Signature: _____ Date: _____

My condition is related to: ___ Work ___ Auto Accident (state _____)

___ Other: _____ Date of injury _____ Date of Surgery _____

How did you hear about us? _____

Social Security# _____

Date of Birth ____/____/____

Status: ___ Single ___ Married ___ Widowed

Work Status: ___ Disabled: ___ Total or

___ Temporary ___ Retired ___ Student: ___ p/t ___ f/t

___ Currently Employed:

Occupation _____

Employer _____

Employer Ph _____

Family MD _____

Family MD Ph _____

2. Payment Info (check only one)

CASH PAYERS

___ I am paying out-of-pocket (cash) for services.

NON-CASH PAYERS

___ I have insurance and would like you to deal directly with them. I will assign my benefits over to you

___ I have an attorney. Please deal directly with them.

My attorney's name is:

Ph# _____

___ I was injured on the job and my employer will be paying the bills. The adjusters name is:

Ph# _____

I consent to be evaluated and treated and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the release of information acquired in the course of my treatment, including but not limited to medical records, electronic and oral communications, to my insurance company representatives, employer, primary care physician, referring MD, and/or other third party payer. I acknowledge having read the Privacy Policy and Patients Bill of Rights.

Patient Signature _____ Date _____