Phone (845)623-6566 **Northeast Rehabilitation, Inc.** **Fax (845)623-6556**
275 N. Middletown Rd. Suite 1B, Pearl River, NY 10965
305 Route 17S, Unit 3-100A, Paramus, NJ 07652
Sudhir V. Tawalare PT., OCS., CHT.
NY License 012255-1, NJ License 40QA00594800
Maria Moldovan, PT NY License 027305

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_____