Patient Information Sheet (Please Print)

Northeastern Rehabilitation ASSOCIATES, P.C.

Patient Name: _____ **Date of Birth:** ____/____/____
Last First Middle I.

Soc. Sec. # : ____/____/____ **Sex:** ☐ M ☐ F

Race: ☐White ☐Black/African American ☐American Indian/Alaska native ☐Asian
☐Native Hawaiian/other Pacific Islander ☐Other _____

Ethnicity: ☐Not of Spanish/Hispanic descent ☐Spanish/Hispanic **Primary Language:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Referring Physician: _____ **Phone:** _____

Emergency Contact _____ **Phone:** _____

Person(s) we may speak with regarding your medical/financial information should the need arise:
Name: _____ **Relation:** _____

■ **Primary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** ____/____/____
Last First Middle I.

Relationship to Patient: _____ **Soc. Sec. #** ____/____/____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____ **Work Phone** _____

Employer: _____

■ **Secondary Insurance Company:** _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** ____/____/____
Last First Middle I.

Relationship to Patient: _____ **Soc. Sec. #** ____/____/____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____ **Work Phone** _____

Employer: _____

Please complete this section if this is a Work Related Injury or Auto Accident:

Patient Name: _____

☐ Work Related Injuries

Date of Injury: _____/_____/_____ Claim #: _____

Employer: _____ County located in: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Contact Name: _____ Phone: _____

☐ Auto Accident

Date of Injury: _____/_____/_____ Claim #: _____

Auto Insurance Carrier: _____

Insurance ID # : _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Contact Name: _____ Phone: _____

☐ Attorney Information - if Applicable

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Dear Patient,

When you arrive for your appointment you will be asked to sign the Patient Authorization Form, as indicated below, electronically. We ask that you take the time to review this information prior to your appointment. You do not need to sign the form below. You may request a signed copy on the day of your appointment.

NORTHEASTERN REHABILITATION ASSOCIATES, PC
PATIENT AUTHORIZATION FORM

I Authorize/Agree:

- The release of any of my medical records to Northeastern Rehabilitation Associates, PC when additional information is needed for my treatment.
- Northeastern Rehabilitation Associates, PC to release my medical information to any other physician or provider to whom I am being referred to for treatment.
- The release of my medical information to my insurance carrier should they need additional information to process and pay for any medical services I receive.
- Payment of my medical benefits to the above stated physician or provider for services rendered to me.
- To accept financial responsibility for any services not covered by my insurance or any other third party payer.

_____ _____

Patient Signature Date

Medicare Patients - Please read and sign:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Northeastern Rehabilitation Associates* for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient Signature Date

Worker's Compensation Patients - Please read and sign:

Worker's Compensation may deny your claim under some circumstances. We routinely ask our patients to provide us with their Secondary Insurance information, as a well as a referral for that insurance from their Primary Care Physician, if required. If your claim is denied, you must assume responsibility for payment of your bill.

_____ _____

Patient Signature Date

Auto Insurance Patients - Please read and sign:

Auto Insurance Companies may deny your claim under some circumstances. We routinely ask our patients to provide us with their Secondary Insurance information, as a well as a referral for that insurance from their Primary Care Physician, if required. If your claim is denied or exhausts, you must assume responsibility for payment of your bill.

_____ _____

Patient Signature Date

6/04,7/05,8/08

Dear Patient,

When you arrive for your appointment you will be asked to sign the Financial Policy, as indicated below, electronically. We ask that you take the time to review this information prior to your appointment. **You do not need to sign the form below.** You may request a signed copy on the day of your appointment.

NORTHEASTERN REHABILITATION ASSOCIATES, PC
FINANCIAL POLICY

INSURANCE INFORMATION...

- You are responsible to notify us of your insurance and to provide the necessary information about your insurance plan, therefore please **have your current insurance card with you at all times.** Please notify us at the time of check-in of any changes in insurance, address, phone numbers, etc.
- Please remember insurance coverage is a contract between you and your insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you. **While you may have insurance coverage to pay your medical bills, you are ultimately responsible for all charges. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.**
- To find out what your insurance plan covers and what your financial obligation may be, call the Customer Service or Member Services department of your insurance company (the phone numbers are on your insurance card) **prior to your appointment**. Make sure that both your physician and the place of service (Hospital, Ambulatory Surgery Center) where services may be performed are listed as a participating provider by your insurance company. It is possible that only the physician or the Hospital/Surgery Center participates with your insurance plan.

REFERRALS...

- **Referrals are the patient's responsibility**. If your insurance requires a referral for your visit and there is not one in place, you will be responsible for payment at time of service or your visit will be rescheduled.
- Referrals typically have an expiration date and a limited number of visits. You should be careful to monitor dates and visits.

PAYMENT INFORMATION...

- **Payment for service is due at time of service.** All co-payments are due at time of service. If you are not prepared to pay your co-pay on the date of service, your appointment will be rescheduled.
- We accept cash, checks, Master Card and Visa.
- Returned Check Fee - Your account will be charged a $25 fee for each returned check. In addition, you will be asked to bring cash to our office or mail a Cashier's check to cover the returned check and the fee.
- Past Due Accounts- Patients who have not made an effort to make payment arrangements may be turned over to a collection agency. Patients who have allowed their account to be turned over to a collection agency will be expected to satisfy their financial obligation to us before returning to see our physicians.
- Our Billing Department is available to discuss any questions you may have regarding your account at 570-344-3788 Opt # 8, Monday through Friday 9:00 am- 4:30 pm.

I have read and understand Northeastern Rehabilitation Associate's Financial Policy as outlined above and agree to adhere to its terms

_____ _____

Patient or Responsible Party's Signature Date

PATIENT PAIN HISTORY:

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

1. Which is your dominant hand? ☐ Left ☐ Right ☐ Ambidextrous
2. What is your main complaint?_____
   _____
   _____
3. Is this the result of a Work Injury? ☐ No ☐ Yes **If yes**, date of injury: _____/_____/_____
   Describe this incident: _____
   _____
   _____
4. Is this the result of a Motor Vehicle Accident? ☐No ☐ Yes **If yes**, date of accident: _____/___/_____
   Describe this incident: ☐ Head-On ☐ Rear-Ended ☐ T-Boned ☐ Other_____
   _____

☐ Driver ☐ Passenger Front Seat ☐ Passenger Back Seat	☐ Loss of consciousness ☐ Airbags deployed ☐ Seatbelt	☐ Ambulance: ☐ C-Collar ☐ Backboard Name of ER: _____

5. If you answered NO to questions 3 and 4, please describe how your illness or injury occurred:
   _____
   _____
6. Have you had anything similar before? ☐ No ☐ Yes **If yes,** please explain:
   _____
   _____
7. Prior to this episode, were you completely symptom free? ☐Yes ☐ No **If no**, please explain:
   _____
   _____
8. What doctors have you seen for this problem?_____
   _____
9. Please answer the following pain-related questions:
   Pain Scale: **0 is no pain** and **10 is the worst pain** you have ever had.

	No Pain										**Worst Pain**
What is your pain level right now?	0	1	2	3	4	5	6	7	8	9	10
In the last 30 days, what has your pain been at its best?	0	1	2	3	4	5	6	7	8	9	10
In the last 30 days, what has your pain been at its worst?	0	1	2	3	4	5	6	7	8	9	10

How frequent is your pain? ☐ Constant ☐Intermittent Explain_____
How long does your pain last? ☐ Less than 1 hour ☐ Less than 1 day ☐All day ☐All night
Is your pain getting: ☐ Better ☐ Worse ☐ Not changing

	Worsens Pain	**Relieves Pain**	**No Effect on Pain**		**Worsens Pain**	**Relieves Pain**	**No Effect on Pain**
Sitting				Standing			
Rising from sitting				Driving			
Walking				Coughing/Sneezing			
Bending forward				Lying on your side			
Bending backward				Lying on your back			
Bending to the side				Lying on your stomach			

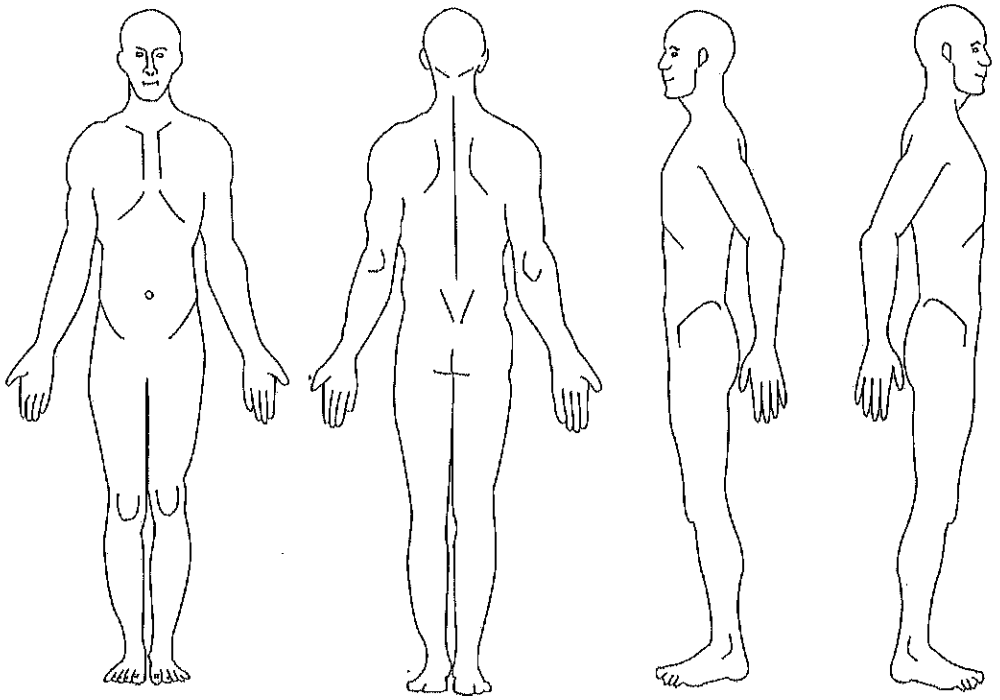
Patient Name: _____

USE THE FOLLOWING SYMBOLS TO INDICATE ON THE DRAWING

EXACTLY WHERE YOUR PAIN IS AT THE PRESENT TIME.

Burning (X) **Numbness (O)** **Pins/Needles (=)** **Stabbing (/)** **Ache (^)** **Throb (V)**

Front Back Left Right



TESTING AND TREATMENTS:

- Which of the following tests have been done for your condition?

☐ X-ray Date:____/____/_____ Facility _____
☐ MRI Date:____/____/_____ Facility _____
☐ Cat Scan Date:____/____/_____ Facility _____
☐ Bone Scan Date:____/____/_____ Facility _____
☐ EMG Date:____/____/_____ Facility _____
☐ Other: _____ Date:____/____/_____ Facility _____

- Please indicate any treatments you have had for your **present** injury and their effect:

	Not Helpful	**Helpful**	**Duration of effect:**
☐ Physical Therapy	☐	☐	_____
☐ Hot Packs	☐	☐	_____
☐ Ice	☐	☐	_____
☐ TENS/ E Stim	☐	☐	_____
☐ Traction	☐	☐	_____
☐ Exercises	☐	☐	_____
☐ Acupuncture	☐	☐	_____
☐ Massage	☐	☐	_____
☐ Chiropractic	☐	☐	_____
☐ Epidural Injection	☐	☐	_____
☐ Trigger Point Injection	☐	☐	_____
☐ Facet Block	☐	☐	_____
☐ Bracing	☐	☐	_____
☐ Psychological Treatment	☐	☐	_____

Patient Name: _____

PAST MEDICAL HISTORY:

Do you or have you had any problems with the following: (Check all that apply)

☐ Alcohol Abuse	☐ Cholesterol	☐ Heart Disease	☐ Liver Disease
☐ Arthritis (Osteoarthritis)	☐ Drug Abuse	☐ Hepatitis	☐ Stroke/ TIA
☐ Arthritis (Rheumatoid)	☐ Diabetes	☐ HIV/AIDS	☐ Thyroid
☐ Asthma	☐ Fibromyalgia	☐ Hypertension	☐ Other _____
☐ Cancer	☐ GERD (Reflux)	☐ Kidney Disease	☐ Other _____

☐ Past Work Injury – Date: _____ ☐ Past Motor Vehicle Accident – Date: _____

Please list surgeries you have had: Date:

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: Please check any diseases/disorders that run in your family. **Do not include yourself.**

Relative	**Relative**	**Relative**
☐ Heart disease _____	☐ Arthritis _____	☐ Hypertension _____
☐ Alcohol Abuse _____	☐ Diabetes _____	☐ Drug Abuse _____
☐ Cancer _____	☐ Other _____	

SOCIAL HISTORY:

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed Number of Children_____

1. Do you Smoke? ☐ No ☐Yes If yes: Packs/Day____ How many years?_____ / ☐ Quit When?_____
2. Do you drink alcoholic beverages? ☐ No ☐Yes If yes, how much per day?_____ Per week?_____
3. Do you use or have you used street drugs? ☐ No ☐Yes
   If yes, what kind and when? _____

EMPLOYMENT STATUS:

1. Job Title/Occupation: _____
2. Briefly describe your job duties: _____
3. Are you currently under work restrictions ☐ No ☐ Yes **If Yes,** what are your restrictions?
   _____
4. Please check current work status:
   ☐ Working Full Time: Hours worked per day_____ Days worked per week _____ Shift_____
   ☐ Working Part Time: Hours worked per day_____ Days worked per week _____ Shift_____
   ☐ Working Light Duty: Hours worked per day_____ Days worked per week _____ Shift_____
   ☐ Off Duty Due to Injury: Date last worked: _____
   ☐ Retired/Not Working

ACTIVITIES OF DAILY LIVING: Please check the level you are presently able to complete the following activities:

	Independent	Need some Assistance	Unable		Independent	Need some Assistance	Unable
Walk	☐	☐	☐	Feed yourself	☐	☐	☐
Dress	☐	☐	☐	Clean your house	☐	☐	☐
Bathe	☐	☐	☐	Care for your family	☐	☐	☐
Drive	☐	☐	☐				

1. Are there other limitations due to current condition?_____
2. At one time, how long can you: Sit _____ Stand_____ Walk_____
3. Do you use any of the following? ☐ Straight cane ☐ Quad cane ☐ Walker ☐ Wheelchair
4. Prior to your injury/illness was your ability to do things at all limited? ☐No ☐Yes
   If yes, please explain: _____
5. Are there stairs to enter/or in your home? ☐ No ☐ Yes How many? ____ Is there a rail? ☐ Yes ☐ No

Patient Name: _____

Review of Systems

Do you have problems with any of the following? Please check all that apply.

General
☐Fatigue
☐Weakness
☐Trouble sleeping

Skin
☐Rashes
☐Dryness
☐Color changes
☐Hair/nail changes

Head
☐Headache
☐Head Injury

Eyes/Ears/Nose/Throat
☐Blurry or double vision
☐Eye pain
☐Blindness
☐Ear pain
☐Ringing in ears
☐Deafness
☐Nose bleeds
☐Dry mouth
☐Sore throat/hoarseness
☐Non-healing sores

Neck
☐Stiffness
☐Swollen glands
☐Pain

Cardiac
☐Palpitations
☐Chest discomfort at rest
☐Chest discomfort with activity

Respiratory
☐Wheezing
☐Shortness of breath with normal activity
☐Shortness of breath with exertion
☐Cough- wet, dry or productive
☐Coughing up blood

Circulation
☐Discoloration of feet/legs
☐Sores/ulcers on feet/legs
☐Swelling of ankles/legs
☐Calf pain with walking
☐Leg Cramps
☐Varicose veins

Gastrointestinal
☐Difficulty swallowing
☐Heartburn
☐Unexplained nausea/vomiting
☐Change in bowel habits
☐Constipation
☐Diarrhea
☐Blood in stool
☐Loss of bowel control
☐Abdominal pain

Genitourinary
☐Frequent urination
☐Painful urination
☐Loss of bladder control

Musculoskeletal
☐Muscle or joint pain
☐Stiffness
☐Back pain
☐Redness of joints
☐Swelling of joints
☐Trauma

Nervous System
☐Dizziness
☐Fainting
☐Seizures
☐Numbness/Tingling

Metabolism/Endocrine
☐Heat or cold intolerance
☐Excessive sweating
☐Increased thirst
☐Change in appetite
☐Recent unexplained weight changes

Hematology
☐Unexplained fevers
☐Ease of bruising
☐Ease of bleeding

Psychiatric
☐Nervousness
☐Depression
☐Anxiety
☐Memory loss
☐Stress
☐Bipolar Disorder
☐Other psychological diagnosis _____

Women Only
☐Currently pregnant
☐Breastfeeding
☐Date of last menstrual period
____/____/_____

Reviewed By:

_____

Date: ____/____/_____

Patient Name: _____

MEDICATION INTAKE SHEET

Please list **all** medications taken on a daily basis, including **vitamins, herbals and over-the-counter** medications. Please list all **medication allergies.** Please list pharmacy name and telephone number.

For Office Use Only: Initial: Ht: _____ Wt: _____ BP:_____ Pulse: _____

Medication Name	Dose/Strength	Times taken per Day	Who Prescribes

Please list any Medications you have tried in the past for this current problem:

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

ALLERGIES: _____

_____

Pharmacy Name _____ **Phone Number**_____

Northeastern Rehabilitation
ASSOCIATES, P.C.

Medication Agreement/Refill Policy

Your treatment plan with NERA may include the care from multiple disciplines, including diagnostic and/ or therapeutic interventions, behavioral medicine, alternative therapies, physical therapy and the prescription use of medications. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us and we need your help to make sure your treatment follows the prescribed guidelines. This agreement is an essential factor in maintaining the trust and confidence necessary in a physician/patient relationship.

Please read each statement and sign the agreement below. If you have any questions regarding this information or practice policy regarding the prescribing of controlled substances, please request clarification.

You acknowledge that you:

1. Understand that there are potential side effects and interactions involved with taking any medication, including the risk of addiction. Other possible complications include but are not limited to: constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration and reduced sexual function. You may develop a tolerance, and become physically dependent on the medication as well. You understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

2. Understand that opiod medications can cause physical dependence within a few weeks of starting opiod therapy. If you suddenly stop or decrease the medication, you could experience withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24- 48 hour of the last dose. You will not stop these medications without consulting your NERA physician.

3. Agree that you are solely responsible for the safekeeping of your medication and prescriptions used in your treatment. Since the drugs may be hazardous to a person who is not tolerant of their effects, especially children, you must keep them out of reach of such people.

4. **Agree that you will treat your medications and prescriptions as you would any valuable possession.** You understand that NERA does not replace LOST OR STOLEN prescriptions or medications or those destroyed by fire, flood, etc.

5. Agree that you will not share, sell, exchange or otherwise permit others to have access to these medications for any reason.

6. Agree that it is your responsibility to keep yourself and others from harm. This includes driving and the operation of machinery while taking medications that may cause drowsiness or impair cognitive function. If there is any question of impairment of your ability to safely perform these activities, you will not attempt to perform the activity until the side effects have had time to resolve.

7. Understand that if you are pregnant or become pregnant while taking medications, your child could be physically dependent on the opiods and withdrawal can be life threatening for a baby. If a female of childbearing age, you certify that you are not pregnant and you will use appropriate contraceptive measures during the course of treatment with medications. Many medications could harm the fetus or cause birth defects.

8. **Agree to take the medication only and exactly as prescribed by your NERA physician. You may not change your medication dosage amounts without prior authorization from your prescribing physician.**

9. Agree to notify NERA if you experience any adverse effects or dosage problems with your prescribed medications. You may be asked to bring any unused medications to NERA for disposal

10. **Agree that you will not use any illegal substance, (cocaine, heroin, marijuana, etc) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and may result in the termination of your care with NERA.**

11. **Agree that if you receive a prescription for a controlled substance from a NERA provider that you will not accept controlled substance prescriptions from any other physician without your NERA physician's consent.** Obtaining medications from multiple sources can lead to drug reactions and poor coordination of treatment. If, for some reason, you encounter an emergency situation and are given controlled substances by a health care professional, you agree to report the facts of this matter to your NERA physician and you consent to the disclosure of all personal health information related to this matter.

12. **Agree to use only one pharmacy for your pain-related medications.** In the event that circumstances require the use of another pharmacy, you will notify NERA of this immediately and provide them with all pertinent contact information.

13. Agree to allow your NERA physician to send a copy of this agreement to your pharmacy, referring physician and all other physicians involved in your care.

14. **Agree to keep all scheduled appointments. You understand that no medication prescriptions/refills will be given for canceled or no-show appointments.** You understand that if you are 15 minutes late for an appointment time, you will be rescheduled for another appointment and no prescriptions/refills will be given.

15. Agree that you cannot be seen at the office without a scheduled appointment for any reason. NERA physicians do not see "walk-in" patients.

16. Understand that it is not our practice to make changes to your prescriptions by telephone.

17. Understand that each prescription is for a specific number of pills, designed to last a certain amount of time. **Early refills generally will not be given.**

18. Understand that you must call the office two days before your prescription(s) will run out so we have sufficient time to process your refill request. Medical Assistants' phone triage hours are from **9AM- 4:00PM, Monday through Friday** for refill requests and questions. Medical Assistants are assisting the doctors during the day and may not be able to speak with you directly at the time of your call. Please leave detailed information and you will receive a call back before the end of the business day. **Calls after 4:00 PM** will be addressed the next business day. **Calls after 4:00 PM on Friday** will be addressed the following Monday.

19. **Agree not to seek medication/refills after office hours, on the weekend, on holidays or prior to next office visit.**

20. Understand that you can be asked to bring any or all of you prescribed medicines to your office appointment or at a random time for a prescription compliance check (Pill Count)

21. Understand that changing dates, quantity, strength of medicines or altering a prescription in any way is against the law. Forging prescriptions or a physician's signature is also against the law. Dealing with forged, falsified, or altered prescriptions will result in your immediate discharge from NERA. NERA cooperates fully with law enforcement agencies in regards to infractions involving prescription medications.

22. Understand that if the responsible legal authorities have questions regarding your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.

23. **Understand that NERA reserves the right to perform a urine drug screen at any time while you are being treated with prescribed, controlled substances.** If the results of the urine drug screen do not reflect medicine prescribed by your physician or you test positive for illegal substances, you understand this may result in the cessation of the prescribing of any controlled substances and you may be discharged from the practice immediately.

24. Understand that the main treatment goal in using pain medications is to improve your ability to function and/or to work and /or reduce pain, In consideration of that goal and the fact that you may be given strong medication to help you reach that goal, you agree to help yourself by following better health habits. This may include exercise, weight control and avoiding the use of nicotine. You agree to comply with the treatment plan as prescribed by your NERA physician.

25. Understand that your medication regimen may be continued for a definitive time period as determined by your NERA physician. Your treatment plan will be reviewed periodically. If there is no significant evidence of improvement or that progress is being made to improve your functioning or quality of life, the regimen may be tapered or possibly discontinued and your care referred back to your primary care physician.

26. Understand that this agreement is important to your physician's ability to treat your pain effectively, and that failure to comply with the agreement may result in the discontinuation of prescribed medication and the possibility of termination of the physician/patient relationship.

27. Understand that inappropriate or abusive behavior or harassment of any NERA staff will not be tolerated. The physicians will determine what actions can be considered harassment on a case-by-case basis and if warranted, you can be discharged from the practice.

28. **Understand that the physicians of NERA may terminate and cancel any prescriptions, and discharge you from the practice if any of the following occurs:**
    - You give, sell, or misuse your pain medication, including but not limited to: taking more medication than prescribed, running out of medication early, obtaining medications at more than one pharmacy,
    - You fail to keep your follow- up appointments,
    - You attempt to obtain pain medication after office hours, on the weekend, on holidays, from any other physician, or any other source,
    - You do not cooperate with requested Pill Counts or Urine screens,
    - Your urine screen shows the presence of medications that your NERA physician is unaware of, the presence of illegal substances, or does not show the presence of medications that your are receiving a prescription for,
    - You are released from the practice for any reason,
    - Any aggressive behavior toward NERA staff or physicians,
    - Any allegations, suspicious information or an investigation is initiated by anyone regarding potential violations of this agreement, is brought to the attention of your NERA physician.

By signing this document you acknowledge that:
- You have thoroughly read, understand and accept all the above provisions.
- You understand that you will receive information from your treating NERA physician regarding the risks and potential benefits of these medications and you should address any concerns regarding your medication regimen with your NERA physician.
- You have received and understand the NERA Prescription Refill Policy.
- You agree to adhere to the terms of this Medication Agreement and the NERA Prescription Refill Policy, knowing that **failure to do may result in termination of treatment with all Northeast Rehab providers.**
- This agreement is in effect for the duration of your treatment.

Your NERA physician understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis. Lack of strict adherence to any provision of this agreement by your NERA physician in no way invalidates any other provision of this agreement. If at any time you are concerned about your medication or side effects of your medication, please contact our office.

Patient Signature _____ Date ____/____/____

Patient Name _____ Date of Birth ____/____/____
Please Print

The pharmacy you have selected is: _____ _____
Pharmacy Name Phone

If you change your pharmacy for any reason, you agree to notify this office at the time you receive a prescription.

Reviewed by Physician/Staff Signature _____ Date____/____/____

6/04, 7/05, 7/10, 1/11,2/12