

Marika Molnar, Physical Therapist, P.C.  
d/b/a WESTSIDE D A N C E PHYSICAL THERAPY

Last Name, First Name: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone#: \_\_\_\_\_ SS#: \_\_\_\_\_

Work Phone#: \_\_\_\_\_ Home Phone#: \_\_\_\_\_

Email address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

WELCOME to Westside Dance Physical Therapy! The following information outlines our policies concerning scheduling, billing and appointment cancellations:

Patients are seen at WSDPT by appointment only and scheduling is based on a first come, first served basis. It is advisable for you to schedule your appointments in advance as the schedule becomes available. Each month's schedule is available by the 15th of the previous month.

Appointments can only be scheduled/cancelled by the reception desk either in person or by phone. Do not expect your therapist to make any appointments or schedule changes for you as schedule books are kept only with the reception.

Please initial \_\_\_\_\_

Your appointment time is very important to us as this time is set aside specifically for you. In the event you need to cancel an appointment, we require at least 24 business hours notice. A cancellation for Monday needs to be made by Friday.

If we do not get at least 24 business hours notice of your cancellation, we may not be able to schedule another patient who may need that time slot. In the event of a late cancellation or "no-show", the full treatment fee will be charged directly to you. Insurance carriers or Worker's Compensation will not pay for these missed visits.

Please initial \_\_\_\_\_

Out of respect for the physical therapy staff and other patients, please make every effort to arrive on time for your appointments. If you realize that you are running late, please call the center.

Patients who carry major medical health insurance should note that professional services are rendered to the patient and not to their insurance carrier and all patients are expected to take care of their fees at the time services are rendered.

I have read the above guidelines and I understand and agree to abide by them:

Signed \_\_\_\_\_ Date \_\_\_\_\_

Marika Molnar, Physical Therapist, P.C.  
d/b/a WESTSIDE D A N C E PHYSICAL THERAPY

AUTHORIZATION TO RELEASE INFORMATION

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Please Print Patient's Name

I hereby authorize WESTSIDE DANCE PHYSICAL THERAPY to provide treatment and to release any information pertinent to my case in the course of my treatment to my physician, insurance company, adjuster or attorney if applicable in this case.

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Signature of Patient/Guardian

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Date

CONSENT FOR A MINOR FOR PHYSICAL THERAPY TREATMENT

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Signature of Patient/Guardian

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Date