Marika Molnar, Physical Therapist, P.C.
d/b/a WESTSIDE DANCE 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 or 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.

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 hour's notice** (a cancellation for Monday needs to be made by Friday).

If we do not get at least 24 business hour's 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/no show of **an initial evaluation a $50 late charge** will be assessed. In the event of a late cancellation/no show of **a follow up appointment**, the **full treatment charge** will be applied. 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 clinic.

Patients who carry major medical health insurance should note that professional services are rendered to the patient and not to their insurance carrier. **All patients are expected to take care of their fees prior to the start of each appointment.** Please initial: _____

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

Signed: _____ Date_____

53 Columbus Ave, Suite 4 New York, NY 10023
Tel 212-541-8450 Fax 212-541-8582

Marika Molnar, Physical Therapist, P.C.
d/b/a WESTSIDE DANCE PHYSICAL THERAPY

AUTHORIZATION TO RELEASE INFORMATION

_____

(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.

_____ _____

Signature of Patient/Guardian Date

CONSENT FOR A MINOR FOR PHYSICAL THERAPY TREATMENT

_____ _____

Signature of Patient/Guardian Date

53 Columbus Avenue, Suite 4 New York, NY 10023
Tel 212-541-8450 Fax 212-541-8582