



Primary Insurance Information:

Patient Information:

Patient's Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Telephone (Home): (____) _____
Telephone (Business): (____) _____
Social Security #: _____
Date of Birth: ____/____/____ Age: _____
Sex: O F O M
Referring Doctor: _____
Occupation: _____

Insurance Company: _____
Member ID: _____
Group #: _____
Policy #: _____
Address: _____
Telephone: (____) _____
Insured (if other than pt): _____
Relationship to patient: _____
D.O.B. of Insured: ____/____/____
Social Security (of insured): _____

Patient Agreement

- 1 Physical Therapy is by physician referral and appointment only.
- 2 If a patient is more than 10 minutes late, treatment may be cancelled and the patient will be charged for the appointment. Prompt attendance is crucial to your recovery.
- 3 A scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE OR THE PATIENT WILL BE CHARGED FOR THAT APPOINTMENT.**
- 4 A late cancellation may be rescheduled **AT NO ADDITIONAL CHARGE** if the appointment is rescheduled in the same Monday-Friday week.
- 5 At the end of the week **ALL** patients including those eligible for No-Fault or Worker's Compensation, **WILL BE DIRECTLY RESPONSIBLE FOR PAYMENT OF \$35.00 FOR EACH MISSED OR LATE CANCELLED (not rescheduled) APPOINTMENT.**
- 6 If a patient misses two appointments without calling to cancel, the patient will be taken off the master schedule and forfeit all permanent appointments.
- 7 If a patient does not honor a rescheduled appointment, either by cancellation or no-show, **THE PATIENT WILL BE CHARGED FOR BOTH THE ORIGINAL CANCELLATION AND THE RESCHEDULED APPOINTMENT.**
- 8 Full payment of the deductible outstanding and initial co-payment is to be paid to Metro Sports P.T. at the time of the initial visit. Physical Therapy co-payments are to be paid at the time of each visit.
- 9 _____ I understand that I will pay all treatment fees directly to Metro Sports P.T.
- 10 _____ I hereby state that I am not eligible for NY No-Fault, NY Worker's Compensation, or Medicare.
- 11 I agree to treatments on the above terms.

Signature: _____

Date: _____