MIDTOWN PHYSICAL THERAPY, PLLC

3534 Riverdale Avenue, Bronx, New York 10463
tel: 347-692-8185 fax: 347-284-1830
www.midtownpt.com

DATE__________________

FIRST NAME________________________ LAST NAME ______________________________

ADDRESS___________________________________CITY____________________________

STATE____________________ZIP CODE____________

SOCIAL SECURITY # _____/_____/_____ DATE OF BIRTH_____/_____/_____

Height: _______ Weight: _________

CIRCLE: MALE FEMALE SINGLE MARRIED DIVORCED WIDOWED

HOME PHONE____________________________CELL PHONE_________________________

WORK PHONE________________EMAIL ADDRESS_________________________________

SPOUSE/PARTNER NAME____

REFERRED BY:____

IF PRIMARY CARE PHYSICIAN; ADDRESS/PHONE

____

EMPLOYERS NAME_______________________________ PHONE_____________________

ADDRESS____

INSURANCE COMPANY NAME____

ID#________________________________ GROUP #________________________________

SECONDARY INSURANCE COMPANY NAME____

ID#________________________________ GROUP #________________________________

RELATION TO INSURED: SELF SPOUSE DEPENDENT CHILD OTHER

IF DIFFERENT FROM SELF;
POLICY HOLDER_____________________________ DATE OF BIRTH_________________

EMERGENCY

CONTACT/RELATIONSHIP_________________________**PHONE**_____________________

MPT CANCELLATION/NO SHOW POLICY

We take great pride in the TIME and SERVICE we provide to our patients.
We take your time very seriously and are committed to serving you with
the highest level of respect, integrity and in the most cost-effective manner.

While some patient cancellations are inevitable, cancellations with less than
24-hours notice and missed appointments are a great expense to the practice and prevent other patients from obtaining those necessary appointment times.

For any cancellation or no show, without a 24 hour notice, there will be a $150.00 fee.
Additionally, for any Monday appointment, a cancellation must be made by the previous Friday before 5 pm.
I understand the policy and hereby authorize MPT to charge my credit card for any cancellation with less than 24 hours notice or no show appointment.

After 3 Cancellations or No Show appointments MPT reserves the right to limit patients to call for same day appointments only.

I CONSENT TO TREATMENT THAT IS RECEIVED IN THIS OFFICE.I HAVE RECEIVED A COPY OF THE OFFICE'S NOTICE OF PRIVACY PRACTICES AND I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS A CLAIM WITH MY INSURANCE. I REQUEST PAYMENT OF INSURANCE BENEFITS EITHER TO MYSELF OR THE PARTY ACCEPTING ASSIGNMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE OR EXPENSES INCURRED THAT ARE NOT COVERED UNDER MY MEDICAL INSURANCE.

Credit Card type Visa, Mastercard, FLexsped, HSA **(NON AMEX):**

Credit Card Number ____

Exp Date _______________ **CCV (three digit number on back)** ________________

SIGNATURE_____________________________________ **DATE**_______/_______/_______