PATIENT INFORMATION

FIRST NAME____________________MIDDLE INITIAL______LAST NAME___________________
(PRIMER NOMBRE) (SEGUNDO NOMBRE) (APELLIDO)

ADDRESS____
(DIRECCION)

CITY_______________________________STATE____________ZIP CODE_____________________
(CIUDAD) (STADO) (CODIGO POSTAL)

WORK TELEPHONE:_______________________HOME TELEPHONE:_________________________
(TEL.DEL TRABAJO) (TEL. DE LA CASA)

MOBILE PHONE:__________________________EMAIL:_____________________________________
(TELEPHONO CELULAR) (CORREO ELECTRONICO)

SOCIAL SECURITY_____________________BIRTH DATE:__________________ SEX: M/F______
(SEGURO SOCIAL) (FECHA DE NACIMIENTO) (SEXO)

EMPLOYER:____
(EMPLEADOR)

EMPLOYER ADDRESS:____
(DIRECCION DEL EMPLEADOR)

PRIMARY INSURANCE:_________________________ ID NUMBER:__________________________

SECONDARY INSURANCE:______________________ ID NUMBER:__________________________

TO ALL PATIENTS:
Please give at least 24 hours notice to cancel a scheduled appointment. For your convenience, our answering machine is available to cancel in advance on nights and weekends. **Late cancellations or no shows will result in a $50 fee being charged to you**. Insurance carriers will not reimburse you for these missed visits. Your weekly bill will reflect these charges and you will be responsible for payment. 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 office. Payment for therapy sessions and missed appointments will be due on the last visit day of each week except for copayments/coinsurance, which will be paid at the end of every visit. I have read the above guidelines and I understand and agree to abide by them:

Signed ____ Date ______________________

672 White Plains Road, Scarsdale NY 10583 (914)722-2400
www.westchestersportspt.com