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## Brooklyn Bodyworks Physical Therapy, P.C. PATIENT AGREEMENT

- New York state law requires that patients obtain a written prescription before initiating treatment by a licensed physical therapist.
- All visits are by appointment only and generally last between 30 and 60 minutes.
- We request that patients call if they are going to be more than 10 minutes late. If a patient is more than 15 minutes late for an appointment, **Brooklyn Body Works PT, PC** reserves the right to cancel the appointment. Remember, this is your scheduled time and the therapist's time is just as valuable as your own time.
- We request **24 hours notification in the event of a cancelled appointment.**
- Any cancellation should be rescheduled** within the same Monday – Saturday period. In other words, if a patient begins the week with two appointments, he or she should complete the week having been seen twice. This is for the benefit of the patient to achieve the highest level of outcome.
- While it is RARELY enforced, BBWPT, PC reserves the right to charge a \$25 cancellation fee for repeated late cancellations or no-show appointments (no phone call prior to cancellation).**
- Should a patient miss two consecutive appointments without calling to cancel, the patient may be taken off the master schedule and may forfeit all further permanent appointments
- PLEASE INFORM THE FRONT DESK STAFF OF ALL SCHEDULING CHANGES PRIOR TO YOUR APPOINTMENT. YOU ARE RESPONSIBLE FOR YOUR SCHEDULE.**
- The patient is responsible for all co-payments and deductibles prior to receiving treatment.**
- Patient is responsible to inform BBWPT, PC of any changes in insurance coverage prior to that change.** If the patient fails to inform BBWPT, PC of a change in insurance coverage, the patient will be held responsible for any unpaid claims related to a lapse or change in benefits.

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\_\_\_\_\_ I understand that I am responsible for my deductible, co-pays and all late cancellation or no-show fees.

\_\_\_\_\_ I hereby state that I am not eligible for NY No-Fault, NY Worker's Compensation.

\_\_\_\_\_ I agree to inform BBWPT, PC of any changes in my insurance coverage or benefits prior to the effective date of these changes.

I agree to treatment on the above terms.

Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

