

**Jonathan Tobkes, M.D.**

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**Payment Method**

Name of Patient: \_\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT (if not self)**

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_ I prefer to pay by check for my sessions

\_\_\_\_\_ I prefer to pay by cash for my sessions.

\_\_\_\_\_ I would like my credit card to be billed for all sessions.