

Rehabilitation Services Attendance Policy

- _____ 1. I agree to call to cancel my appointments at least 24 hours in advance.
- _____ 2. I agree that I will be no more than 15 minutes late for my appointments. I understand that arriving late will be considered a “no show” and that my treatment time may be limited or possibly not provided.
- _____ 3. I agree not to schedule a vacation or extended leave of absence for the duration of my scheduled treatment sessions.
- _____ 4. I understand that a **total of two (2)** cancellations and/or “no shows” will result in discharge from therapy. I understand that my physician will be notified of my failure to show for appointments and the resultant discharge from therapy.
- _____ 5. I will **refrain** from using my **Cell Phone** during my sessions as to not interfere with my treatment time or other equipment usage.

P.T. Days: _____ Time: _____

O.T. Days: _____ Time: _____

SP. Days: _____ Time: _____

Advance Directive Notification

_____ I have been informed of my right to have an Advance Directive and have been offered the Advance Directive Policy pamphlet.

Co-Pay and/or Deductible Notification

While we make every attempt to verify the co-pays and deductibles your insurance requires, **YOU ARE RESPONSIBLE** to know your level of financial responsibility for co-pay and deductibles. These amounts are our best estimate of your costs based upon the information available to us.

_____ I have been informed that my insurance requires me to pay a co-pay of _____ per _____.

_____ I have been informed that my insurance requires me to pay a deductible of _____.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____