



CANCELLATION, NO-SHOW AND MISSED APPOINTMENT POLICY

In order to succeed in physical therapy please help us serve you better by keeping your regularly scheduled appointments to complete the individualize plan of care established by you and your physical therapist. **All cancellations must be called in by phone. We require you to call a minimum of 24 hours in advance if you are unable to keep a scheduled appointment or no-show/cancellation fees may apply.** This courtesy allows us to offer that appointment time to another patient.

READ AND INITIAL THE FOLLOWING INFORMATION. PLEASE ASK FOR CLARITY IF YOU DON'T UNDERSTAND THE INFORMATION PROVIDED

_____ I understand that a 24-hour notice is required to cancel any scheduled appointment to avoid a cancellation fee of \$75.00 per each appointment that I miss or no-show for, or do not cancel within the 24 hour notice, assessed at Rose City Physical Therapy's sole discretion. Rose City Physical Therapy does understand that emergencies do occur and will attempt to make reasonable accommodations for that.

_____ If a missed, no-show or cancellation fee is assessed, these charges will be my responsibility and charged directly to me and are due at my next visit before physical therapy is continued. These charges cannot be billed to my insurance company (see below *NOTE* for Workman's Compensation insured cases).

_____ [*NOTE: Workman's Compensation Cases only*] If my case is a Workman's Compensation case, Rose City Physical Therapy is not allowed to charge me for appointments that I miss or no-show for or did not cancel within the 24-hour notice. However, I do understand that Rose City Physical Therapy will notify my workman's compensation carrier and/or case manager to alert them of appointments I miss or no-show for, or have cancelled with or without a 24-hour notice and this may jeopardize acceptance of my claim and lead to denial.

_____ **I understand if I miss three or more appointments during my course of care, whether a no-show or cancellation with or without a 24-hour notice,** I am subject to possible discharge and my physician/referring provider (and Workman's Compensation carrier and/or case manager if applicable) will be notified. I also understand once I have been discharged, I will need a new physician's referral/prescription to continue further physical therapy and will be receiving a new evaluation.

Thank you for understanding our policy. Please let us know if you have any questions or concerns.

PATIENT PRINTED NAME:	Date
PATIENT (or Parent/Legal Guardian) SIGNATURE:	
Parent/Legal Guardian PRINTED NAME:	
Witness (Authorized Signature of Rose City PT Employee):	Date