

## APPOINTMENT CANCELLATION POLICY

Dear Patient,

We strive to provide excellent physical therapy care to you, your family, and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets aside ample time for a patient. "No-shows" and late cancellations inconvenience those individuals who need access to care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented an Appointment Cancellation Policy and it is effective immediately. Our policy is as follows:

1. We request you give our office a 24- hour notice in the event you need to reschedule your appointment. Our phone number is 907-235-7473.
2. If you miss an appointment and do not contact us with at least 24 hours prior notice, we will consider this a missed (no-show) appointment and a **\$25.00 no-show fee** will be assessed to you. This applies to late cancellations and "no-shows."
3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.
4. We have set up reminders if you have requested to receive them. *It is ultimately the patient's responsibility to remember his or her scheduled appointments.*
5. It is Summit Physical Therapy, Inc.'s policy that patients will be discharged due to noncompliance after 3 non-exempt cancellations or no-shows.
  - a. Exempt cancellations include unforeseen circumstances/emergencies or illness.
  - b. All other cancellations are non-exempt.
6. Any patient who is currently being seen for a Worker's Compensation case: the Worker's Compensation adjuster will be notified after 2 no shows or non-exempt cancellations as well as at the time of discharge due to noncompliance.

This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is due within 30 days of the cancelled appointment expected in a timely fashion and if not, will be subject to collections.

***I have read and understand the Appointment Cancellation Policy and agree to the terms of this policy.***

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name