Purpose: The purpose of this agreement is to facilitate a high quality of therapeutic care, on a consistent basis, to help you restore of improve your functional abilities. In order to achieve this goal, the following points must be understood and honored.

Please initial next to each:

_____ **Cancellations**: Please notify scheduling at 727-3601 *at least 24 hours prior* to your appointment.

_____ **Cancellation Policy**: If there are 3 cancellations within a month, you may be discharged and your physician will be notified. If discharged, a new referral is necessary to begin therapy. If you return, the initial appointment will be considered as a new evaluation; therefore, all admitting paperwork is required.

_____ **No Show Policy**: If you do not cancel your appointment and do not arrive at the scheduled time, this is considered a "No Show" appointment. If there are 2 no show appointments in one month, you will be discharged from therapy *(See cancellation policy above regarding discharge)*.

_____ **Arrival:** Please arrive **15 minutes** prior to your scheduled time to allow time to check in.

_____ **Late Arrival:** In the event of a late arrival *(15 minutes)*, we will attempt to provide your scheduled service; however, your therapy may be delayed or the time of your session may be shortened.

_____ **Medical Emergencies:** If you experience a medical emergency during your outpatient therapy visit, staff will contact 911 for emergency response intervention. Patients will not be asked if they have an Advanced Directive, since this is not an applicable setting.

_____ **Unsupervised Children:** A child may be accompanied if another adult/caregiver is present to watch the child during your appointment.

I have read, understand, and initialed the above:

Date	Time	Signature ❑ Patient ❑ Legal Representative
Date	Time	Witness Signature