Purpose: The purpose of this agreement is to facilitate a high quality of therapeutic care, on a consistent basis, to help you restore or 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 ___________________