CANCELLATION / NO-SHOW POLICY

PURPOSE:

This policy ensures that we can offer timely appointments to patients who need them.

PROCEDURE:

1. Your consistent attendance and participation is imperative to your progress. Therefore, if the recommended plan of care is not followed and/or you are not making progress in your treatment plan, you will be discharged and your physician notified. If this occurs, a new referral for therapy will be necessary to set up a new therapy schedule.

2. Please arrive 5-10 minutes before your scheduled appointment to ensure that you obtain the treatment you need. If you arrive 15 minutes late for a scheduled appointment, your appointment will be considered a cancellation and you will need to reschedule.

3. If you need to cancel an appointment, please provide notification 24 hours in advance of your appointment. If you cancel three appointments without proper notification, you will be removed from our schedule.

4. If you have more than one no-show (fail to attend a scheduled appointment and fail to provide any notification), you will be removed from our schedule.

I, __________________________ hereby acknowledge that I have received a copy of the Cascade Medical Notice of Privacy Practices as well as the Therapy Department Cancellation / No-Show Policy.

_____________________________  _________________________________
Date                                      Signature of Patient or Patient’s Representative

_____________________________
Relationship (parent, legal guardian, personal representative, etc.)