Privacy Policy Acknowledgment

_____ I have received the Health Information Privacy Notice and I have been provided an opportunity to review it.

I, _____ give my consent for Advance Physical Therapy Services, LLC to share my health information with anyone.

- ☐ Name: _____ Relationship: _____
- ☐ I do not give permission to share my information with anyone.

Non-Covered Services Waiver

_____ I understand that my health insurance coverage has certain restrictions and limitations such as authorization requirements, non-covered services and supplies.

No Show/Cancellation Policy

_____ The time of the therapists at Advance Physical Therapy is valuable, as is your time. We kindly ask for a minimum of 24 hours notice for any cancellations or rescheduled appointments. We understand that sometimes it is difficult to plan for the unexpected and, therefore, we will allow leeway for the first two no show appointments.

Following two no show appointments, based on the decision by your therapist, you may either:

- Pay $50 per No Show (payment must be received before future appointments can be made)

  OR

- Be discharged from Physical Therapy

Please sign the bottom of this policy indication that you were made aware of our procedure for missed visits. Thank you.

Patient Signature: _____Date: _____

Advance PT Representative Signature: _____Date: _____

Office Coordinator: File this form in patient chart