Cancellation and No Show Policy

Pinnacle Physical/Occupational Therapy has a cancel/no show policy. We would like for you, the patient to understand that your appointments are important for your recovery process.

If you fail to attend your initial evaluation appointment or do not give us 24 hours advanced notification, a $50 cancel/no show fee will be applied to your account. If you fail to attend a follow up appointment or do not give 24 hours advanced notification, a $25 cancel/no show fee will be applied to you account.

This fee is your responsibility and will not be paid by your insurance.

Consent to Treatment

I understand that I have been referred for rehabilitation services/treatment and care to Pinnacle Physical/ Occupational Therapy. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Pinnacle Physical/Occupational Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to best of my knowledge. I understand fully the payment policy and procedure of Pinnacle Physical/Occupational Therapy. I hereby authorize Pinnacle Physical/Occupational Therapy to furnish my insurance company(s), Attorney, or legal representatives all information that said parties may request concerning my present illness or injury. I hereby assign Pinnacle Physical/Occupational Therapy all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to Pinnacle Physical/Occupational Therapy. It is understood that any money received from the above named parties over and above my indebtedness will be refunded to me when my bills are paid in full. I understand that I am financially responsible to Pinnacle Physical/Occupational Therapy for charges not covered by my insurance company(s). I certify by my signature below that I read and agree to this information.

We make every effort to begin your therapy services at your appointed time.

If you are more than 15 minutes late for your scheduled appointment, you may be asked to reschedule your appointment.

Patient Signature____ **Date** ___________________

If under age of 18 parent or guardian signature required below

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Relationship to patient: Parent, Guardian, Spouse, etc.

(Revised 03/30/2011)