Privacy Policy Acknowledgment

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

Non-Covered Services Waiver

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

No Show/Cancellation Policy

X _____ The time of the therapists at Connolly 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 day-of or less than 24-hour cancellation or no-show appointments. Beyond that, you will be charged $50.00 per no show appointment or cancellation within 24 hours of your scheduled appointment.

Following no-show or less than 24-hour cancellation 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).
- Charge your insurance company for your missed visit.
- Be discharged from Physical Therapy and incur the No Show Charges for ALL missed visits.

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

Patient Signature: **X** _____Date: **X**_____

Connolly PT Representative Signature: _____Date: _____

Office Coordinator: File this form in patient chart 09/23/2018