No Show Policy

If you are unable to make your scheduled appointment, please call at least **four hours** prior to the appointment. We will attempt to call you if we do not see you within 15 minutes of your scheduled time. You will be charged a $15 fee for each no-show. This fee is not covered by your insurance. After three no-show or three consecutive cancellations, your Physical Therapist reserves the right to discharge you from our clinic.

Signature: ____ Date: ________________

Medicare Benefits

I request payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished me by that Physician/Supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits payable for related services.

Signature: ____ Date: ________________