Late Cancellation & No-Show Policy:

This policy has been established to provide the highest level of Physical Therapy Service to all Patients seen at Progressive Physical Therapy, LLC. It has been proven that consistent attendance provides for the greatest opportunity for success. Furthermore, by providing timely notice of a cancellation, we may be able to accommodate other patients with your appointment slot.

- Patients must call at least **24-hours** prior to their scheduled time, when they knowingly are unable to make their appointment. Cancellations within 24-hours of appointment will be considered a *late cancellation*.

- A patient will be allowed to continue with their therapy after one no-show/late cancellation, provided a reasonable **explanation** is supplied to the Therapist and/or Front Office Staff.

- **After two (2) no shows/late cancellations, the patient will be charged $50.00**. This fee must be paid in cash or check before the patient's next appointment.

- **After three (3) no shows/late cancellations, the patient will be discharged from treatment.** At this time, a letter will be sent to physician and all future appointments will be removed from schedule.

- We understand that emergencies arise and that it may not be possible to give such a notice. Exceptions to the No-Show/Late Cancellation Policy will be determined by Progressive Physical Therapy's Management Team.

To help avoid the consequences listed above, Progressive Physical Therapy's Office Staff will remind patients of their appointments in in three ways: 1.) An **e-mail invitation** is sent through Google-Calendar once an appointment has been scheduled. 2.) A **reminder-call** will be made the workday prior to the scheduled appointment (unless patient chooses not to be called), and 3.) A **copy of upcoming appointments** can be printed if requested by the patient.

By signing below, I state my agreeance to Progressive Physical Therapy's, *Cancelation and No-Show Policy*. I understand that missed appointments affect three people: **Myself:** I am not receiving the treatment prescribed for my condition. **My Physical Therapist:** Has reserved that time for me specifically. **Another patient:** who could have been seen in my place.

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Patient/ Guardian Signature Date