

Cancellation and No Show Policy

Patient's name: _____ Date: _____

Thank you for choosing **Precision Physical Therapy, Inc.** to provide your physical therapy and massage needs. Please read the following two policies, initial each one, then sign your name at the bottom of the page.

Cancellation Policy:

If you need to cancel a Physical Therapy appointment, please call us ASAP (4 hours notice) so we have the opportunity to offer your appointment to another patient. If less than 4 hours notice is given you will be charged a \$30 cancellation fee.

Initial _____

If you need to cancel a Massage Therapy appointment, please call us ASAP (24 hours notice) so we have the opportunity to offer your appointment to another patient. If less than 24 hours notice is given you will be charged a \$30 cancellation fee.

Initial _____

No Show Policy:

If you do not show up for a scheduled appointment, you will be charged a \$30 no show fee.

Initial _____

I understand the terms of this form. I realize that I am financially responsible for charges incurred from cancellations or no shows.

Patient's signature: _____

Parent's signature (if patient is a minor): _____