

STRAIT

Physical Therapy

Specializing in you

Patient Name: _____

Consent to Treatment

I hereby authorize STRAIT Physical Therapy, through its appropriate personnel, to perform the following for the above named patient: an Examination, Evaluation, Diagnosis/Prognosis, Intervention, Outcome analysis, and Discharge planning. I further authorize STRAIT Physical Therapy to release any information acquired during the course of my or the above named patient's treatment to the appropriate medical personnel or insurance carriers.

Patient Signature: _____

No Show / Cancellation / Lateness Policies

STRAIT Physical Therapy allocates specific time for your treatment to meet the needs of your rehabilitation program. We understand your time is valuable and we ask that you reciprocate that same attitude toward us. If you must cancel an appointment, we require 24 hours notice. We recommend you promptly reschedule that visit in order for you to meet your rehabilitation needs.

If you do not cancel within 24 hours or no-show an appointment, you will be charged a fee of \$50_____ (initial), which is not covered by your insurance and will be due prior to your next scheduled treatment. All cancellations and no-show appointments are documented in the chart and become part of your medical record. If you are a Worker's Compensation case, your case manager and physician will be notified immediately of any missed appointments. The following applies for inclement weather: If Fairfax County Public Schools (FCPS) are **closed**, patients may call to cancel their appointment the day of their scheduled appointment and not incur the cancellation fee. If FCPS open **2 hours late**, all *morning* patients (ie. 7am, 8am, 9am and 10am) may call to cancel their appointment that day without penalty.

We recognize the possibility of unforeseen reasons to be late for appointments; however, in order to be fair to other scheduled patients, STRAIT Physical Therapy holds to the following policy:

We cannot fulfill your scheduled treatment beyond lateness of 15 minutes of your appointment. Beyond 15 minutes of your scheduled appointment will be deemed as a No Show/Cancellation and you will be billed \$50 accordingly as referenced above. We strongly recommend that if you encounter an unforeseen circumstance, you contact STRAIT Physical Therapy as soon as possible to make alternative arrangements. Thank you.

I understand and agree to these terms.

Patient Signature:

Guarantor:

(If patient is a minor)

Date:
