

## **Cancellation/No Show policy**

Thank you for choosing Advance Physical Therapy as your physical therapy provider.

We are sincerely dedicated in assisting you meet your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program which will result in quicker recovery and better outcomes.

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule your appointment and open that time slot for another patient. If you are calling after hours you may leave a message at 985/448-5888. Canceling an appointment with short notice or no-showing an appointment takes up clinic time that could benefit another person.

We take these policies seriously because when a patient misses an appointment, three people are adversely affected:

1. You, the patient- for not receiving the treatment you need
2. Your therapist- as now he or she has a gap in the schedule
3. Another patient- who could have had your appointment time

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having pain or not having pain are NOT reasons to cancel or fail to show for your scheduled treatment. If you are in pain, it is important to come in because there are treatments available and/or program modifications that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your course of treatment to correct the underlying causes of your injury which will prevent future setbacks.

We want to make your physical therapy experience as beneficial as possible and your commitment is a very important part of this. If you know you are going to have a difficult time making your appointments, please discuss with your therapist. We will try to accommodate your needs.

Thank you.

Patient Name (print): \_\_\_\_\_

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_