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**POLICY**

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_/\_\_\_\_

Thank you for choosing **Elevation Physical Therapy** to provide your rehabilitative and / or personal training needs. Please read the following two policies, initial each one, and then sign your name at the bottom of the page.

**Cancellation Policy:**

If you need to cancel a 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 $25 cancellation fee.

Initial\_\_\_\_\_\_\_\_

**No Show Policy:**

If you do not show up for a scheduled appointment, you will be charged a $25 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_