



Appointment Cancellation and No-Show Policy

PLEASE READ THIS POLICY PRIOR TO YOUR FIRST APPOINTMENT.

YOU WILL BE ASKED TO SIGN THIS POLICY AT THE TIME OF YOUR FIRST APPOINTMENT AND IT WILL BECOME PART OF YOUR MEDICAL RECORD.

SportsPlus Sports Medicine and Physical therapy Center is committed to providing you, our valued patients, with excellent quality and convenient physical therapy services. We reserve time in our schedule specifically for you. Therefore, we ask your cooperation by making every effort to keep scheduled appointments.

Consistent attendance of all physical therapy sessions is very important to your overall success and cancellations and no-shows are highly discouraged. Chronic late arrivals are disruptive to the successful implementation of your plan of care. Please arrive on time for your appointment. If you are more than 15 minutes late for your appointment you may be asked to wait until your therapist is available or, more likely, to reschedule your appointment and have a cancellation recorded for that day.

We ask that you give 24-hours notice if you must cancel an appointment. If we do not get adequate notice we may not be able to schedule other patients who would benefit from that time slot. We have an answering machine if you need to call after normal business hours or over the weekend. Our number is 641-753-6636.

All cancellations and no-shows will be recorded as part of your medical record. Three last minute cancels and/or no-shows (without reasonable excuse) will result in discharge from physical therapy services.

Please **DO NOT CANCEL** if you are feeling worse or believe the treatments are not working. Keep your appointment and discuss your concerns with your therapist. Please understand that your pain may fluctuate as your course of treatment progresses.

Please **DO NOT CANCEL** if you are feeling better. Keep your appointment in order to progress your plan of care and prepare for discharge.

Thank you for your cooperation in these matters.

Patient Name (Print):

Patient Signature:

Date:

Parent/Guardian Signature:

Relationship to Patient: