SUPERIOR
Physical Therapy and Sports Rehab

Previous Patient? Y / N Date: ________________________________

Last Name __________________________ First Name _________________________ MI __________________

Street Address ____

City __________________________ State ______ Zip ____________ Ailment ____________________________

Telephone: Home (______) ______ - ______ Cell (______) ______ - ______ Work (_____) _____ - _____

Email ____

Would you like to receive appointment reminders by Email? Y / N

Date of Birth _____/_____/_____ Social Security # ______/______/______

Emergency Contact _________________________________ Phone (_____) ______ - ______

Referring Physician ________________________________ PCP ______________________________

How did you hear about us? Ad ( ) Sign Doctor ( ) Ins. Co. ( ) Website ( ) Friend ( )__________________

Appointment time needed _________________________________ Flexible Schedule? Y / N

Primary Insurance Information

Who is the insured? Self ( ) Spouse ( ) Parent ( ) Other ( )

Last Name _____________________________ First Name ____________________________ MI ______________

Telephone: Home (_____) ________ - _______ Cell (_____) ______ - ______ Date of Birth ____/_____/______

Social Security # _______/_______/_______ Name of Ins. Co ____

ID # _______________________________________ Group # ____

I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for healthcare services or supplies may be made directly to Superior Physical Therapy. I also acknowledge that by signing below, I hereby accept the terms and agreements made by the Patient Registration Form.

____ _____________________ __________________

Signature of Responsible Party Relationship to Patient Date

Superior Physical Therapy & Sports Rehab
www.Frederickpt.com

65 D Thomas Johnson Dr.
Frederick, MD 21701
301-663-7898

9093 Ridgefield Dr, STE 201
Frederick, MD 21701
301-696-5595

Consent for Medical Treatment Policy

1. **Consent for Health Care Services**: I authorize consent for medical treatment at Superior Physical Therapy

2. **Authorization for Release of Information**: Superior Physical Therapy may release information from my medical records to any healthcare provider involved in my care and treatment. Superior Physical Therapy may also release information from my medical records to any person or organization liable for all or part of my charges, such as insurance carriers, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Superior Physical Therapy is no lumber responsible for the confidentiality of any information known or possessed by payer.

3. **Financial Agreement**: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Superior Physical Therapy which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Superior Physical Therapy, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Superior Physical Therapy. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.

4. **Workers Compensation, Auto Claims, and Other Legal Cases**: I understand that on or before the initial visit, accurate and current information is to be given to Superior Physical Therapy to file the insurance claim. Superior Physical Therapy will also make copies of my personal health insurance card(s). My personal insurance information will be kept on file for 10 months; at the end of 10 months if no progress is being made in my legal case Superior Physical Therapy will file these claims to my personal health insurance. I understand that I will be responsible for any deductibles, copayments or coinsurance.

5. **Preauthorization Requirements**: I accept the responsibility to obtain all referral or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Superior Physical Therapy charges. I understand that if the required referral or pre-authorization is not obtained, I am responsible for full payment for all services rendered.

6. **Assignment for Direct Payment**: I authorize that payment of any insurance benefits (including health insurance, auto insurance workers' compensation) for healthcare services or goods to be paid directly to Superior Physical Therapy.

7. **Rescheduling Appointments**: I understand it is my responsibility to contact Superior Physical Therapy in the event I need to change any scheduled appointments.

8. **Electrodes for Electrical Stimulation**: Due to declining reimbursements, it is our policy at Superior Physical Therapy & Sports Rehab that if a patient receives electrical stimulation as part of their treatment they are required to purchase

their own electrodes for $5.00. These electrodes will be labelled & used for your personal use only. Insurance will not cover this charge and it will be each patient's financial responsibility.

Consent for Medical Treatment

I acknowledge that:

- I have read the consent for Medical Treatment form and understand its contents.
- I am the patient or person duly authorized, either by the patient or otherwise, to sign this agreement, to consent to and to accept its terms.
- I am responsible for payment of all copayments at the time of service and for full payment of any balance due within 30 days of receiving a billing statement.
- I have received a copy of Superior Physical Therapy's Consent for Medical Treatment Policy.
- All information that I have provided to Superior Physical Therapy is true, accurate and completed to the best of my knowledge.

_______________________________________ _______________________________________

Signature of Patient/Responsible Party Date

_______________________________________ _______________________________________

Patient/Responsible Party's Printed Name Relationship to Patient

Insurance Waiver

I understand that if Superior Physical Therapy is not an in-network participating provider for my insurance company, I agree to pay all charges and will submit on my own for reimbursement of any charges from my insurance company.

_______________________________________ _______________________________________

Signature of Patient/Responsible Party Date

_______________________________________ _______________________________________

Patient/Responsible Party's Printed Name Relationship to Patient

Please, take your time filling out this form. It is imperative that we have accurate information to be able to complete a thorough assessment and help us pursue the best course of action.

Last Name: ________________________ First Name:________________________ DoB: ____/_____/_____

Height: __________ Weight:_________

Currently I am experiencing (circle all that apply) Was this an automobile accident? Y or N. If yes, date:_________

Fever/chills/sweats	Poor balance	Unexplained weight gain/loss
Numbness/Tingling	Changes in appetite	Difficulty swallowing
Depression	Shortness of breath	Dizziness
Headaches	Malaise	Abnormal heart rate
Night sweats	Nausea/vomiting	Lightheadedness
Chest pain	Swelling	Double vision

Was this a work related accident? Y or N. If yes, date:_______________
Any time off work? Y or N. If yes, date(s):______________________
Have you had any surgery(s) Y or N. If so, list with dates:
____
____
____

Medication List: Please bring a current list of medications that includes dosage, frequency, route (orally, IV, drops, etc.)
If not, please fill out the medication list page.

High Blood Pressure______
Heart Disease or Heart Attack_______
High Cholesterol______
Asthma______
Allergies______
Bronchitis______
Blood Disorders_______
Emphysema_______
Anemia_______
Diabetes________
Hypoglycemia_______
Concussion_______
Fractures_______

Fainting______
Anxiety/Panic Attack_______
Arthritis______
Hepatitis_______
Kidney Disease/Stones______
Spinal Cord Injury______
Ulcers______
Seizures______
TMJ Disorder________
Blood in Stool________
Depression________
Cancer_______
STD_________

Liver Disease______
Traumatic Brain Injury_____
Thyroid Problems_______
Bowel/Bladder Incontinence______
Abdominal Pain______
Polio/Muscle Disease_______
Migraines/Headaches_______
Sleep Disorders_______
Lyme Disease_______
Chronic Fatigue_______
Fibromyaigia_______
Gynecological Disorders________
Osteoarthritis________

Please answer the following questions:

1. Are you a smoker? Y or N If so, how long?_______ How many packs/day?________
2. Do you drink? Y or N If so, how many drinks/wk?_________
3. Are you taking a blood thinner? Y or N
4. Do you have a pacemaker or any other medical transplant equipment? Y or N
5. If you answered "yes" to Cancer, please list type(s):_________________________________
6. If you answered "yes" to fractures, please list type(s) and date:_________________________
7. If you answered "yes" to arthritis please list type(s):__________________________________
8. Please list any pertinent family medical history:_______________________________________
9. If you are a female athlete, do you skip meals during the day or secretly eat meals?__________________
   a. Are you having irregular or absent menstrual cycles?_________________________
   b. Have you noticed any wide fluctuations of weight?__________________________

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things?YES NO

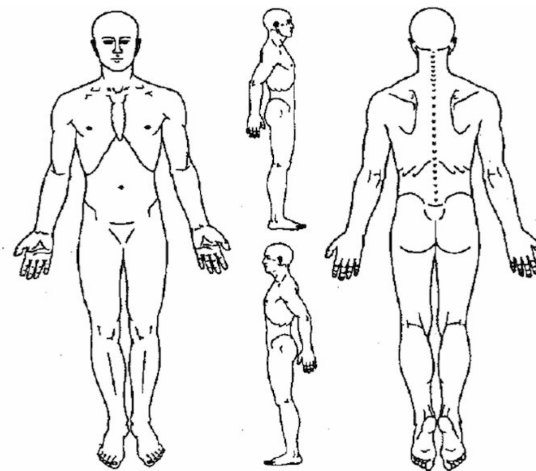
Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

This section is meant to help us assess your current condition:

- Please tell me where you feel your current pain/symptoms ______________________________
- About when did your pain/symptoms start?______________________________
    - Did your pain come on (circle one) Sudden Gradually
    - Was there an injury/trauma? Y or N If yes, what?______________________________
    - Are your symptoms (circle one): getting better or getting worse or about the same
- Have you received any treatment or this problem in the past? ______________________________
    - If so, what treatment and did it help?______________________________
- Are you experiencing any (circle one): extreme fatigue weight loss change in bowel/bladder function
- Did you have a recent surgery? Y or N. If yes, what kind?______________________________
    - Do you have swelling? Y or N. If so, where?______________________________
    - Does the area feel warm or is it red? Y or N. Do you have point tenderness? Y or N
    - Do you have pain? Y or N. If yes, please fill out the pain diagram below:

Please identify where your pain and symptoms are located. Please use a (?) if pain is different from the ones listed below:



If necessary, please describe your condition further: ______________________________

____

____

____

Please rate your pain on a scale of 0 - 10 (0 being no pain and 10 being worse pain you could ever imagine)

• Currently:	1	2	3	4	5	6	7	8	9	10
• Average over 72 hours:	1	2	3	4	5	6	7	8	9	10
• Worse over 72 hours:	1	2	3	4	5	6	7	8	9	10
• Best over 72 hours:	1	2	3	4	5	6	7	8	9	10

- What makes your symptoms/pain worse:
  ____
- What makes your symptoms/pain better:
  ____
- What are your personal goals with therapy?
  ____

I have answered the above questions to the best of my ability. I understand that this information will only be used in my healthcare operations to help provide me with the most accurate and best care.

Patient Signature: ____ Date:____

Medication List (if you don't have a copy of your current medications, dosage, frequency, and route, this form will help you maintain an accurate list for future medical needs). If you have a list, just write "see list under medication and fill out the rest of form.

Medication	Dosage	Frequency	Route	Reason

Have you had any recent changes in your medication dosage, frequency, or type? Yes or No
- If yes, please describe changes: ____
Do you feel that your medication is contributing to any falls, dizziness, or other symptoms you are experiencing? Yes or No
- If yes, please explain: ____
Have you ever been on long term use of corticosteroids? Yes or No
- If yes, when, and for how long? ____
Have you, or are you, taking any performance enhancing drugs? Yes or No
- If yes, what are you taking? ____

The above list of medications is accurate to the best of my knowledge:

Patient Signature: ____ Date: ____

Please write, in your own words, the nature of your current medical problem:

____

____

BLADDER SYMPTOMS: (Please answer all questions)

Circle true, false, or not applicable (N/A), whichever is more appropriate:

1.	I leak urine. If true, how long have you leaked urine? ____________________	T	F
2.	I have to wear pads because of urine loss. If true, what kind? __________________	T	F
3.	Is the pad fully saturated when you change it? ________ yes ___________ no	T	F
4.	My bladder problem is bad enough that I have asked/thought about asking my doctor about surgery.	T	F
5.	I had a bladder operation. Abdominal approach ________ Vaginal approach ____________	T	F
6.	I urinate more than 6x/day	T	F
7.	I urinate more than 2x/night	T	F
8.	My urine stream is consistent	T	F
9.	My urine stream starts and stops	T	F
10.	I have difficulty starting the urine stream	T	F
11.	I dribble urine after using the restroom	T	F
12.	After I urinate, I feel that my bladder is not completely empty	T	F
13.	My urine loss is a continual drip, so that I am constantly wet	T	F
14.	I leak urine when I cough, sneeze, laugh, or exercise	T	F
15.	I lose urine in small amounts	T	F
16.	I lose urine in large amounts and once it starts, I cannot stop the flow	T	F
17.	I often feel the urge to urinate before I leak	T	F
18.	I often leak when I am on the way to the bathroom	T	F
19.	The sound/sight of running water make me experience an urge to urinate	T	F
20.	I have pain in the region of my bladder	T	F
21.	It hurts to urinate	T	F
22.	I often lose urine during intercourse	T	F
23.	I have 2 or more bladder infections per year	T	F

BOWEL SYMPTOMS:

1.	I leak feces. If yes, how often? ________________________________	T	F
2.	I have difficulty with passing gas when I don't want to	T	F
3.	I have trouble with constipation	T	F
4.	I use laxatives. If true, how often __________________ what kind? _______________________	T	F
5.	I have 2 or more bowel movements per week F		T
6.	I have to "bear down" hard to have a bowel movement	T	F
7.	I feel that my bowels are never fully empty	T	F
8.	I have trouble with hemorrhoids	T	F
9.	My bowel movements are painful	T	F

What are your feelings about your current medical condition on a scale of 1 to 10?

0 1 2 3 4 5 6 7 8 9 10

(no impairment) (severe impairment)

How long does it take you to drive to our office? ____

GYNECOLOGY:

1. Date of last pap smear ____________ Normal? ________ yes _________ no
2. Date of last menstrual period ____________________________________
3. Have you ever had a STD? _______ yes _______ no. If yes, when? ____
4. Have you been sexually assaulted? __________ yes __________ no
5. Do you feel as if your organs are "falling out" _________ yes __________ no
6. Do you have trouble with pelvic pain? _________ yes __________ no* If yes, describe

____

*If no, skip to question #15

7. Do you have pain with intercourse? ________ yes _________ no
8. Are you currently secually active? _________ yes _________ no

Dyspareunia is a medical term that describes painful penetration, which is graded on 3 levels:
Level 1 - penetration is painful, but sexual activity occurs with same frequency
Level 2 - penetration is painful, which limits sexual activity frequency
Level 3 - painful and prevents penetration.
Which level are you? _______________________

9. During painful penetration, do you feel: (please circle as many as apply) burning, stinging, ripping, pain, friction

10. Do you feel pain with deep penetration?
Where is the pain? _______ vagina ______ bladder ________ back __________ hips ________ other
Explain ____

11. Can you reach orgasim? _______ Yes ________ No
12. Does it make the pain worse? _______ Yes __________ No

13. Do you have pain, burning, or discomfort in the:
__________ Clitoris _________ Vagina __________ Labia ___________ Anus

14. How long has the pain been present? ___________ How did the pain start?
____

15. Menopause? __________ Yes __________ No. If no, skip to the next section.

Have you been on Hormone Replacement Therapy (HRT)? ________ Yes _________ No
Are you currently on HRT? _______ Yes ________ No

Dosage: Type:
Estrogen_______________ Pills_____________ Cream_____________ Patch________________
Progesterone____________
Other_________________
If HRT was stopped, why? ____

Obstetrical History: ________ Not Applicable
Number of pregnancies _________ Number of vaginal deliveries ________ Number of C-Sections __________
Number of miscarriages _________ Age of children ___________________________
Number of episiotomies _________ Do you have a painful episiotomy scar? ______ yes ________ no
If applicable, please describe any complications during childbirth: ____
____
Are you planning to have children/any more children? ___________ yes _________ no
Are you currently attempting to become pregnant? _____________ yes __________ no

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Your Information. Your Right. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with thom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Ruin our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say no to your request, but we will tell you why within 60 days

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say yes to all reasonable requests

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say no if it would affect your care
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose or payment or our operations with your health insurer. We will say yes unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another within 12-months

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints /.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear performance for how we share your information in the situations described below, talk to us.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example, if you are unconscious, we may share your information if we believe that it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Treat you

- We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research
- We can use or share your information for health research

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective date: December 1, 2014

To obtain more information about your privacy rights or our privacy policies, you may contact our Privacy Officer.

Earl Cox
Superior Physical Therapy & Sports Rehab
65D Thomas Johnson Dr.
Frederick, MD 21701
earl@frederickpt.com
(301) 663 - 7898

Acknowledgement of Receipt of Notice of Privacy Practices Under HIPAA Guidelines

Please sign, print and date on this acknowledgement form, then detach the form from the Notice and return your signed acknowledgement to the receptionist.

Printed Name: ____

Signature: ____ Date: ______________________

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Name: ______________________________________ DoB: ________/_________/__________

Release of Information

( ) I authorize the release of information including diagnosis, treatment and financial information to the following people:

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

( ) This information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please contact me at: ( ) Home ( ) Work ( ) Cell ( ) Email

If unable to reach me:

( ) You may leave a detailed message

( ) Please leave a message asking me to return your call

( ) ____

The best time of day to reach me is between ___________________ am/pm and __________________ am/pm

Signed: ____Date: _________/_________/_______

Consent For Evaluation and Treatment of Pelvic Floor Dysfunction

I acknowledge and understand that I have been referred to Superior Physical Therapy Women's Health Program for evaluation and treatment of my pelvic floor dysfunction. Pelvic floor dysfunctions include but are not limited to pelvic floor muscle weakness, pelvic organ prolapse, incontinence, bladder, bowel or sexual dysfunctions, chronic vulvar or pelvic pain, painful scars after childbirth or surgery, persistent sacroiliac or low back pain.

I understand that to evaluate my condition it may be necessary initially and periodically to have my therapist perform an internal pelvic floor muscle assessment. This assessment is performed by observing and palpating the perineal area including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, muscle length, strength and endurance, scar mobility and function of the pelvic floor region. I understand that I can refuse the internal examination at any time. The physical therapist that will be performing the internal assessment has had extensive education and training pertaining to the pelvic floor.

Treatment may include but not be limited to the following: observation, palpation, perineal biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I understand that no guarantees have been or can be provided regarding the success of the therapy. I hereby request and consent to the evaluation and treatment to be provided by the therapists, therapy assistants or technicians of Superior Physical Therapy and Women’s Health Program.

______________________________ ______________________________
Patient Signature Printed Name

______________________________ ______________________________
Date Witness

LATE CANCELLATION/NO SHOW POLICY

Please Read Carefully

We pride ourselves on our one-on-one approach with therapy and your successful outcome with physical therapy. We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Missed appointments have a significant impact on the outcome of your physical therapy results as well as the clinic and other patients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. PAtients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment will be responsible for a $50.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

2. We reserve your appointment time just for you so that we may provide optimum treatment outcomes for all of our patients. 24-hour notice allows us to place another patient in your cancelled appointment period to receive needed treatment.

3. Certain accident claims adjusters expect regular attendance to physical therapy as requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis, it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. After missing 2 appointments without notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

______________________________ ______________________________

Signature of patient or responsible party Date

I certify that I have reviewed this policy with the above patient.

______________________________ ______________________________

Signature of Superior PT Employee Date