



In order to optimize your therapy, we ask that you please do the following:

- ❖ Arrive on time for your appointment. If you are going to be more than 15 minutes late to your appointment, please call us to reschedule.
- ❖ Please sign in for treatment each day.
- ❖ Please familiarize yourself with the 24 hour cancellation policy (*refer to the section below*).
- ❖ Please schedule ahead; 6-10 visits to ensure your preferred appointment time and continuity of care.
- ❖ Wear loose fit clothing appropriate for exercise. Please do not wear jeans, dress shirts, skirts which can make treatment difficult.
- ❖ Please leave food and beverages outside of the clinic (you may bring your own bottle of water).
- ❖ Please wash your hands and feet before treatment (if you are a foot/ankle patient).
- ❖ Please remove your shoes while on the treatment tables and equipment.
- ❖ Please turn off your cell phones.

### **Cancellation/No Show Policy**

A 24-hour notice is required in the event of a cancellation or a no show. Failure to provide such notice will result in a charge of \$50.00 (day of cancellation) and \$75.00 (no show) which will not be covered by your insurance; rather it will be billed directly to the patient.

- ❖ We require a credit card to be put on file in our encrypted system.
- ❖ We do our best to remind you of your appointments however, scheduling and cancelling appointments is ultimately your responsibility. Failure to do so will result in the above referenced charges.

**Credit Card Information:**

\_\_\_\_\_ Visa

\_\_\_\_\_ MasterCard

Name on Credit Card: \_\_\_\_\_ Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ 3-Digit Security Code: \_\_\_\_\_

**Billing Address:**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

***The above information has been explained to me. I understand that in the event of a late cancellation or no show, I authorize Core Performance Physical Therapy to charge the amount of \$50 for a late cancellation and \$75 for a no show.***

\_\_\_\_\_  
*Patient/Parent/Guardian Name (Print Name)* *Patient*

\_\_\_\_\_  
*Patient/Guardian Signature* *Patient/Pare*  
*Date*