



Attendance Policy

(Please read thoroughly)

Elkins Physical Therapy Service strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

We know that life is full of surprises, and we know that at times you will need to cancel or reschedule an appointment. We kindly ask that you let us know as soon as possible to allow an opportunity for another patient to be scheduled. Know that last minute cancellations, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients.

EPTS Cancellation and No-Show Policies

- If you are more than 20 minutes late for your appointment and fail to notify us, the appointment will be cancelled, and a fee charged for missing the appointment.
- Scheduled appointments **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE**, or a fee will be charged for that appointment.
- Failure to show up for an appointment (“NO SHOW”) without notifying us will result in a fee being charged for that appointment.
- Two consecutive no-shows, without communication will result in the cancellation of all remaining scheduled appointments.
- **ALL PATIENTS, regardless of insurance/third party payor, will be charged a \$30 CANCELLATION FEE for each late cancelled, cancelled, or no-show appointment.**
- THE PATIENT IS RESPONSIBLE FOR THE CANCELLATION/ NO-SHOW FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.
- All cancellations and no-shows will be documented in the medical record and appropriately reported to your physician and insurance/third party payor.

This policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All of the staff at Elkins Physical Therapy Service appreciates your adherence and cooperation with this policy. .

Patient Acknowledgment Signature: _____

Date: ____ / ____ / ____