Altruistic
THERAPY SERVICES

CANCELLATION / NO SHOW / RESCHEDULE POLICY

Dear Patient,

We strive to provide excellent rehabilitative care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for a patient. When there are missed appointments, it greatly affects your progress and rehabilitation outcomes.

"No-shows", and late cancellations inconvenience those individuals who need access our services in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Cancellation Policy and it is effective immediately. We understand that emergencies and unfortunate events arise at times. Therefore we will allow a maximum of one courtesy cancellation which also must be re-scheduled within the same week.

Our policy is as follows:

1. We request you give our office a 24-hour notice in the event you need to reschedule your appointment.
2. You MUST call your therapist and a re-schedule must be attempted.
3. If you miss an appointment and do not contact us with at least a 24 hour prior notice, we will consider this a missed appointment and a **$50.00** fee will be assessed to you. This applies to late cancellations and "no-shows."
4. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.
5. It is ultimately the patient's responsibility to remember their scheduled appointments. This fee will be billed to you directly and **is not** covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.
6. Negligent compliance with scheduled sessions may result in an immediate discharge from our services and a letter will be sent to your referring physician explaining poor compliance with the plan of care.

We thank you for trusting Altruistic Therapy Services, LLC. with your medical care.
I have read and understand the **CANCELLATION / NO SHOW / RESCHEDULE POLICY** and agree to the terms of this policy.

Signature:_____

Printed Name:_____

Date:_____

0: 810.886.1028 f: 866 886 6628 124 S. State Rd. Davison MI 48423 altruisticsls.com