ALLIANT
PHYSICAL THERAPY GROUP

Privacy Practices Acknowledgement

Please Initial

_____I have received the Health Information Privacy Notice and I have been provided an opportunity to review it.

Non-Covered Services Waiver

_____I understand that my health insurance coverage has certain restrictions and limitations such as authorization requirements, non-covered services and supplies.

No Show/Cancellation Policy

_____The time of the therapists at Alliant Physical therapy is valuable, as is your time. We kindly ask for a minimum of 24 hours notice for any cancellations or rescheduled appointments. We understand that sometimes it is difficult to plan for the unexpected and, therefore, we will allow leeway for the first two no show appointments.
Following two no show appointments, based on the decision by your therapist, you may either:

- Pay $50 per No Show (payment must be received before future appointments can be made)

  OR

- Be discharged from Physical Therapy

Please sign the bottom of this policy indicating that you were made aware of out procedure for missed visits.
Thank you.

Patient Signature:_____Date_____

Alliant PT Representative Signature:_____Date_____

Office Coordinator: File this form in patient chart