SPINE AND SPORTS REHABILITATION CENTER
CANCELLATION/NO SHOW, HIPAA AND CONSENT FORM

Patient Name: _____

CANCELLATION/NO SHOW POLICY AGREEMENT

It is our desire at Spine and Sports Rehabilitation Center to provide each patient with the highest quality of services in the most expeditious manner. Therefore, we provide a reserved time slot for each patient so that there is minimal waiting and each person receives individual attention.

In order for us to continue with this service, we ask that you call at least 24 hours in advance if you are unable to keep your scheduled appointment. After 2 cancellations without 24 hour notice, or no shows, you will be charged for the appointment time, at a rate of $ 40.00.

Additionally, 4 missed appointments (no show or without 24 hours notice) during the course of your treatment will require us to discharge you from physical therapy and inform your physician, case manager and/or insurance carrier of your discharge status.
We appreciate the opportunity to provide your rehabilitation care. Thank you for your consideration to our staff and other patients who may need your appointment time, if you can't make it.

HIPAA

_____ I HAVE received a copy of the Notice of Privacy Practices from Spine and Sports Rehabilitation Center.

_____ I have chosen NOT to receive a copy of the Notice of Privacy Practices from Spine and Sports Rehabilitation Center.

PATIENT CONSENT TO EVALUATION AND TREATMENT

As a patient of Spine and Sports Rehabilitation Center (SSRC), you have the right to be informed about your condition and the recommended physical therapy procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.
I voluntarily request Conrad & Renzi, P.A. dba SSRC and such associates, technical assistants and other health care providers may deem may necessary to treat my condition which has been/will be explained to me. I understand that the following procedures are planned for me and I voluntarily consent to authorize the procedures for evaluation and treatment of my condition.
I understand that no warranty or guarantee has been made to me as a result or cure. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment, the procedures to be used and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.
I certify this form has been explained to me and that I have read it or have had it read to me, and that I understand its contents.

Patient Signature
Or Legal Representative _____ Date _____

SSRC Representative _____ Date _____

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