



## Kirkland and Novelty Hill Physical Therapy

### Cancellation – No show Policy

*Effective January 01, 2019*

The therapists and staff of Kirkland and Novelty Hill Physical Therapy are glad you are here. **You** are the reason this Physical Therapy practice exists, and we promise to never forget that! Your successful rehabilitation is our top priority. To achieve the best possible outcome, we and/or your doctor have recommended a particular treatment schedule. To attain these results, it is very important that you attend your therapy sessions as scheduled.

We promise that 100% of our effort will go into your rehabilitation, but we need 100% from you as well. We reserve time in our schedule specifically for you. With this in mind, we ask your cooperation by making every effort to keep scheduled appointments.

Please review the guidelines we have put in place to ensure that you get the most out of your experience at Kirkland and Novelty Hill Physical Therapy.

- 1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment will be responsible for a \$75.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.**
- 2. If, you are late for an appointment, you will be seen as soon as possible, and for the length of time remaining to your appointment. If you are over 20 minutes late your appointment may have to be rescheduled and you will be charged a \$75.00 office visit charge.**
- 3. For Worker's Compensation and Auto insurance clients, we are obligated to inform your case manager of any missed treatment sessions.**
- 4. When you do not show as scheduled, three people are hurt. You, because you did not get the treatment you need; the therapist, who now has a space in his/her schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.**

I understand the terms of this form. I realize that I am financially responsible for charges incurred from cancellations or no shows.

**Print Name:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Responsible Party (if applicable):** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

Copy given  
to patient

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