



PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require a 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a \$15.00 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Debbie Snyder
Yadkin Physical Therapy

I have read and understand this policy: _____ Date: _____



PATIENT INFORMATION ACKNOWLEDGEMENT

I have read and fully understand the Notice of Information Practices of Yadkin Physical Therapy, L.L.C. I understand that Yadkin Physical Therapy, L.L.C. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Yadkin Physical Therapy, L.L.C. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in the Notice of Information practices of Yadkin Physical Therapy, L.L.C. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

Patient Name	Age
Signature	Occupation
Date	Family MD

Yadkin Physical Therapy may leave a message on any answering machine or voicemail at any of the phone numbers I provide or speak with the person who answers.

Yes No Initials: _____ Date: _____

(Home) (_____) _____ - _____

(Work) (_____) _____ - _____

(Cell) (_____) _____ - _____

Please list any medications you are currently taking
Drug Allergies



Please list any surgeries that you have had.	Date of surgery:

Case Manager (if applicable):	Attorney (if applicable):
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Please check all that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Allergy to bee stings | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Angina/chest pain |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Visual problems |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Sudden weight loss | <input type="checkbox"/> Cancer | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Sleep disorders |
| <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Other: _____ | | | |

Consent for treatment

Knowing that I suffer from a condition or injury requiring physical therapy services, I hereby voluntarily consent to physical therapy treatment encompassing a physical therapy evaluation, treatments per the therapist’s discretion, and re-evaluations at least monthly by the therapist and/or trained staff.

The staff of Yadkin Physical Therapy, L.L.C. is hereby released to the extent permitted by law from all legal responsibilities, which may arise out of patient’s care and treatment.

I acknowledge awareness that the staff of Yadkin Physical Therapy, L.L.C. provides no guarantees as the result of treatments or examination.

I (We) have read and fully understand the above and I (we) fully and freely accept and consent to treatment.

_____	_____	_____
Patient	Witness	Date
_____	_____	_____
Responsible Co-Signer	Witness	Date

