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**CANCELLATION AND NO SHOW POLICY**

Date: \_\_\_\_\_

To ensure fairness to all of our patients and respect the time set aside for you and your therapist, **our policy is that we require a twenty-four hour notice for all cancellations. Failure to give adequate notice will result in a \$35 charge, which is not covered by your insurance. Failure to show for an appointment without any notice will also result in a \$35 charge, which is not covered by your insurance.** If the patient no shows three times during the course of their treatment sessions, the physical therapist reserves the right to either discharge the patient, or restrict the times the patient may schedule further appointments.

I, \_\_\_\_\_ understand and agree to the terms stated above and understand that failure to abide by the cancellation and no show policy will result in a charge that is my responsibility.

\_\_\_\_\_  
Signature (Parent or Guardian)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name