PATIENT MISSED APPOINTMENT POLICY

We here at SoFLo PT, strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your 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 to ensure the most optimum results. We expect you to keep all your appointments. We will provide you with a calendar at the front desk for all your appointment times. 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 24-hour notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk. However, due to the popularity of our staff we cannot guarantee that we will be able to reschedule you to keep you compliant with your plan of care. **In an instance of cancellation, without 24-hour notice, we reserve the right to charge you a $25.00 fee. In an instance of a no-show you will be charged a $50.00 fee.** In instances of repeated noncompliance 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.

TREATMENT COMMITMENT

SoFlo PT cares very much about each person we treat. We are committing to you, our patient, to deliver Exceptional Care, with Exceptional Results! We request of you, our patient, to deliver a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at SoFlo Pt:

1. Attending, on time, all scheduled appointments.
2. Informing your therapist of your progress, each visit.
3. Compliance with your treatment plan developed by your therapist.
4. Asking questions when you do not understand any instructions given to you by our staff.
5. Notifying your therapist in advance of your next doctor's appointment.

Together, we can accomplish the task set before us, as a team. That's the way healthcare is meant to be.

MVA POLICY(Auto)

For your convenience, we will attempt to bill your automobile insurance if the policy includes personal Injury protection (PIP) coverage. Please note, we cannot bill the other person's auto insurance.
At the point your automobile PIP is exhausted, we will bill your health Insurance or offer a Self-Pay Option.
Please provide the front office this information before your visit.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize South Florida Physical Therapy & Sports Rehab, to obtain my Protected Health Information including, but not limited to, History and physical exam, lab reports, progress notes, X-ray reports, substance abuse (including alcohol/drug abuse), Mental Health (including psychotherapy notes), HIV related information (including AIDS related testing). I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

_____ _____

Patient's Signature/ Insured Date