1CNT

Patient Name _____ Date of Birth _____

Physician Name _____ Date _____

We appreciate you choosing our facility for your therapy services. Your therapist has recommended your initial treatment to be _____ times per week for _____ weeks. Based on your progress, the frequency or duration of your treatment may be adjusted in the future.

We want to ensure you are aware of the importance of consistency in your attendance of these appointments. First and foremost, we are committed to assisting you to the highest level of functional independence as possible. This requires consistent delivery of the therapy service specific for your plan of care. Second, we will reserve a therapy staff member to work specifically with you during your appointment times.

We realize that scheduling conflicts do occur and ask that you contact us as soon as you realize you have a conflict. Our goal will be to reschedule that appointment within the same week. Regulations that govern our therapy service require that your physician reviews your plan of care.

Our policy includes:

- Forwarding a copy of the initial evaluation/plan of care to your physician.
- Forwarding pertinent revisions to your plan of care to your physician.
- Notifying your physician when missed visits potentially affect your plan of care.
- If applicable, notifying your insurance representative of missed visits.

My signature below reflects that I have been informed and understand the above and states my commitment to attending my appointments.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Patient Label