Late Cancellation and No Show Policy Fee

We understand that situations arise in which you must cancel your appointment. It is requested that if you must cancel your appointment you do so by **3pm the day prior** to your appointment. Effective immediately, clinical treatment appointments which are cancelled or "no show" on the same day will be subject to a **$35.00** same day no show/late cancellation fee.

We understand that special unavoidable circumstances may cause you to cancel a scheduled appointment on the same day. Fees in this instance may be waived only if that appointment is rescheduled the **same week** or the **following week** on available appointment times.

Please sign that you have read and understand this Late Cancellation and No Show Policy.

____ __________________

Patient or Legal Guardian Signature Date

____ __________________

Witness Date

Notice of Provider Privacy Practices

By signing this form, you are granting consent to Southeastern Physical Therapy to use and disclose your protected health information (PHI) and electronic protected health information (EPHI) to a third party provider for the purposes of treatment, payment, health care operations, to include all information contained in my patient records.

Also, by signing this consent you acknowledge a copy of the Notice of Privacy Practices as been offered to me and I understand my rights as a patient. ___________(initial)

Southeastern Physical Therapy will not disclose PHI/EPHI to a third party without your consent. Notice of Privacy Practices provides more detailed information about how we may use and disclose this PHI/EPHI. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised noticed by contacting Southeastern Physical Therapy at 4668 Pembroke Blvd, Suite 115, Virginia Beach, VA 23455.

You have a right to request us to restrict how we use and disclose your PHI/EPHI for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement, you have a right to revoke this consent in writing, and except to the extent we already have used or disclosed your PHI/EPHI in reliance on your consent.

Upon request treatment in a private room is available. ________(initial)

____ __________________

Patient or Legal Guardian Signature Date

____ __________________

Witness Date