At Lydia Taft House

Please provide us with the following information:

First Name ___________________ **M.I.** ____ **Last Name** ______________________

Telephone (Home) _____-______-_______ **Date of Birth** ______-_____-_________

CANCELLATION/LATE FEE: I hereby acknowledge that I have been informed that I am responsible for **notifying** *Uxbridge Orthopedic & Sports Therapy* **NO later than 24 hours before a scheduled appointment**. If a cancellation has been made within 24 hour of a scheduled appointment, or If I **show up to my appointment late** and am unable to be treated at the scheduled time, I will be responsible for paying a **$40.00** cancellation fee. Excessive cancellations (more than 3) within a treatment cycle may result in discharge from services & may require a physician's note to resume.

INITIALS: [ ]

NO SHOW POLICY: I hereby acknowledge that I have been informed that if I have a "No Call/No Show" for my appointment I will be responsible for paying a **$40.00** No Show Fee. Excessive absenteeism (more than 3 No shows in a treatment cycle) may result in a DISCHARGE from therapy and my physician will be notified.

INITIALS: [ ]

AUTO ACCIDENT INJURIES: I hereby acknowledge that it is my responsibility to inform *Uxbridge Orthopedic & Sports Therapy* if my injuries are related in anyway to an auto accident. I understand that this clinic only bills my health insurance for diagnosis that are not related to an auto accident and will not bill any car insurance for payment. If for any reason my health insurance denies payments for treatment, I am fully financially responsible for services rendered.

INITIALS: [ ]

RECEIVING SERVICES FROM ANOTHER HEALTH CARE ORGANIZATION: I hereby acknowledge that it is my responsibility to ***inform*** *Uxbridge Orthopedic & Sports Therapy* if I am currently receiving any services from a health care organization including: ***Home Health Care from VNA services*** at the same time I am being treated here for therapy ***OR*** had received any ***PT, OT, SLP,*** or ***Nutrition Counseling*** services at any other facility this year. If for any reason my health insurance denies payments for therapy treatment, I am fully financially responsible for services rendered.

INITIALS: [ ]

PICTURE RELEASE (Optional): I hereby give *Uxbridge Orthopedic & Sports Therapy* consent for my picture to be taken and used for either treatment education, to be placed in a brochure and/or on the company website.

INITIALS: [ ]

______________________________ ______________________ __________
Signature of Patient (or Responsible party) Print Full Name Clearly Date

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Relationship to Patient (if signing for patient)

______________________________ ______________________ __________
Witness Signature Print Full Name Clearly Date

Revised 4/26/2016