



# Patient Registration

(Please complete all pages. Thank you.)

## PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)		EMAIL ADDRESS	
ADDRESS		SOCIAL SECURITY NUMBER	DATE OF BIRTH
CITY	STATE ZIP		
HOME TELEPHONE NUMBER	CELL TELEPHONE NUMBER	WORK PHONE NUMBER	MALE FEMALE (circle one)
FAMILY PHYSICIAN	MARTIAL STATUS	OCCUPATION/EMPLOYER	

Would you like to join our email list to receive news, updates and specials? Yes/No

How did you hear about us? Check one. Doctor \_\_\_\_\_ Advertisement \_\_\_\_\_  
 Friend/Relative (who?) \_\_\_\_\_ Other \_\_\_\_\_

## WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT?

\_\_\_ Myself \_\_\_ My Spouse \_\_\_ My Parent(s)

## INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company:
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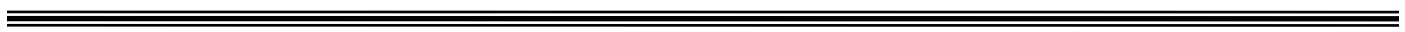
Please give your insurance card/cards to the receptionist so they can make a copy for your record.

## POLICY HOLDER'S INFORMATION (If NOT the patient)

NAME	RELATIONSHIP TO PATIENT	EMPLOYER
ADDRESS (if different from above)		DATE OF BIRTH
CITY	STATE ZIP	HOME TELEPHONE (if different from above)

## EMERGENCY CONTACT

NAME (Last, First, Middle Initial)	RELATIONSHIP TO PATIENT
ADDRESS	CITY STATE ZIP TELEPHONE #



# Patient History

1. Describe the current problem that brought you here?

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2. When did your problem first begin? \_\_\_ months ago or \_\_\_ years ago.

3. Was your first episode of the problem related to a specific incident? Yes/No  
Please describe and specify date

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4. Since that time is it: staying the \_\_\_ same \_\_\_ getting worse \_\_\_ getting better. Why or How?

5. If pain is present rate pain on a 0-10 scale, 10 being the worst. \_\_\_\_\_ Describe the nature of the pain  
(i.e. constant burning, intermittent ache)

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6. Describe previous treatment/exercises

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7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> Sitting greater than _____ minutes                | <input type="checkbox"/> Sexual activity                          |
| <input type="checkbox"/> Walking greater than _____ minutes                |   |
| <input type="checkbox"/> Standing greater than _____ minutes               | <input type="checkbox"/> With cough/sneezes/straining             |
| <input type="checkbox"/> Changing positions (i.e. – sit to stand)          | <input type="checkbox"/> With laughing/yelling                    |
| <input type="checkbox"/> Light activity (light housework)                  | <input type="checkbox"/> With lifting/bending                     |
| <input type="checkbox"/> Housework   | <input type="checkbox"/> With triggers –running water/key in door |
| <input type="checkbox"/> Yard Work   | <input type="checkbox"/> With nervousness/anxiety                 |
| <input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump) | <input type="checkbox"/> No activity affects the problem          |

What relieves your symptoms?

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8. How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify \_\_\_\_\_

Diet/Fluid intake, specify \_\_\_\_\_

Physical activity, specify \_\_\_\_\_

Work, specify \_\_\_\_\_

Other \_\_\_\_\_

9. What are your treatment goals/concerns?

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10. Please list below any medication/supplement/vitamins taken on a regular basis (please include dosage)

\_\_\_\_\_

11. Are you allergic to any medications? Yes / No  
 If yes, please lists: \_\_\_\_\_

12. Please list all prior surgeries: \_\_\_\_\_

13. Do you have any metal implants or pins? Yes / No

14. Have you had unexplained weight gain or weight loss in the past month? Yes / No  
 Current Height and Weight: \_\_\_\_\_

15. **Since the onset of your current symptoms have you had:**

- |  |                                 |
|--|---------------------------------|
| Y/N Fever/Chills                         | Y/N Unexplained muscle weakness |
| Y/N Unexplained weight change            | Y/N Night pain/sweats           |
| Y/N Dizziness or fainting                | Y/N Numbness/ Tingling          |
| Y/N Change in bowel or bladder functions | Other/describe _____            |
| Y/N Malaise (unexplained tiredness)      | _____                           |

16. Bladder/Bowel Habits/Problems

- |                                      |   |
|--------------------------------------|---|
| Y/N Trouble initiating urine stream  | Y/N Trouble emptying bladder completely   |
| Y/N Urinary intermittent/slow stream | Y/N Straining or pushing to empty bladder |
| Y/N Trouble emptying bladder         | Y/N Dribbling after urination             |
| Y/N Difficulty stopping urine stream | Y/N Constant urine leakage                |

17. Do you have or have you had any of the following?

	Now	Past		Now	Past
Dizziness/ Vertigo			Diabetes		
Stroke			Arthritis		
Severe headaches			Osteoporosis		
Blurred Vision					
Double Vision			High blood pressure		
Ringling in your ears			Shortness of breath		
Nausea			Asthma		
Epilepsy			Chronic Bronchitis		
Multiple Sclerosis					
			Irregular heartbeat		
			Chest Pain		
Depression			Heart disease		
Chemical Dependency			Heart Attack		
Fever			Pacemaker		
Confusion			Congestive Heart Failure		
Pain in Calves			Peripheral Vascular Disease		
Muscle Pain			Thrombophlebitis		
Fatigue			Anemia		
Skin Disorder			Hemophilia		
Smoker			Cancer		
How many Packs a day? _____			Please list type _____		
			Thyroid problems		
Tuberculosis			Kidney/ Bladder Problems		
Hepatitis C			Liver Problems		

Acquired Immune Deficiency/ HIV			Abdominal pain/discomfort		
Hepatitis B			Ulcer/ Colitis		
			Hernia		

18.If your family has a history of any of the above please list:

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19. List any other information regarding your medical history not detailed above:

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20. Have you fallen in the past 2 years? If so, how many times and approximately when did the fall(s) occur?

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## Pelvic Symptom Questionnaire

### Bladder/ Bowel Habits/ Problems

Y/N Trouble initiating urine stream

Y/N Urinary Intermittent/ slow stream

Y/N Trouble emptying bladder

Y/N Difficulty stopping the urine stream

Y/N Straining or pushing to empty bladder

Y/N Dribbling after urination

Y/N Constant urine leakage

Y/N Blood in urine

Other/describe \_\_\_\_\_

Y/N Painful urination

Y/N Trouble feeling bladder urge/fullness

Y/N Current Laxative use

Y/N Trouble feeling bowl/urge/fullness

Y/N Constipation/straining

Y/N Trouble holding back gas/ feces

Y/N Recurrent bladder infections

1. Frequency of urination: awake hour's \_\_\_\_\_ times per day, sleep hours \_\_\_\_\_ times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? \_\_\_\_\_ minutes, \_\_\_\_\_ hours, \_\_\_\_\_ not at all.
3. The usual amount of urine passed is: \_\_\_\_\_ small, \_\_\_\_\_ medium, \_\_\_\_\_ large.
4. Frequency of bowel movements \_\_\_\_\_ times per day, \_\_\_\_\_ times per week, Or \_\_\_\_\_.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? \_\_\_\_\_ minutes, \_\_\_\_\_ hours, \_\_\_\_\_ not at all.
6. If constipation is present describe management techniques  
\_\_\_\_\_
7. Average fluid intake (one glass is 8 oz or one cup) \_\_\_\_\_ glasses per day. Of this total how many glasses are caffeinated? \_\_\_\_\_ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/ pressure:  
 \_\_\_\_\_ None present  
 \_\_\_\_\_ Times per month (specify if related to activity or your period)  
 \_\_\_\_\_ With standing for \_\_\_\_\_ minutes or \_\_\_\_\_ hours.  
 \_\_\_\_\_ With exertion or straining  
 \_\_\_\_\_ Other

*Skip questions if no leakage/incontinence*

9. Bladder leakage – number of episodes  
 No leakage  
 Times per day  
 Times per week  
 Times per month  
 Only with physical exertion/cough
10. On average, how much urine do you leak?  
 No leakage  
 Just a few drops  
 Wets underwear  
 Wets outerwear  
 Wets the floor
11. What form of protection do you wear? (Please complete only one)  
 None  
 Minimal protection (Tissue paper/paper towel/pantishields)  
 Moderate protection (absorbent product, maxipad)  
 Maximum protection (Specialty product/diaper)  
 Other \_\_\_\_\_
- On average, how many pads/protection changes are required in 24 hours? \_\_\_\_\_ # of pads
- Bowel leakage – number of episodes  
 No leakage  
 Times per day  
 Times per week  
 Times per month  
 Only with exertion/strong urge
- How much stool do you lose?  
 No leakage  
 Stool staining  
 Small amount in underwear  
 Complete emptying

## Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed below, please circle the number on the scale that describes the level disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

**Family/Home Responsibilities:** This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. house work) and errands or favors for other family members (e.g. driving the children to school)

No Disability    0    1    2    3    4    5    6    7    8    9    10    Worst Disability

**Recreation:** This disability includes hobbies, sports, and other similar leisure time activities.

No Disability    0    1    2    3    4    5    6    7    8    9    10    Worst Disability

**Social Activity:** The category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability    0    1    2    3    4    5    6    7    8    9    10    Worst Disability

**Occupation:** This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

**Sexual Behavior:** This category refers to the frequency and quality of one's sex life.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

**Self Care:** This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

**Life-Support Activities:** This category refers to basic life supporting behaviors such as eating, sleeping, and breathing

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

\*\*I certify that the information I have provided is complete and true to the best of my knowledge.

I understand that I am financially responsible for all charges at the time services are rendered. I further understand that *ABove Physical Therapy*, LLC will provide me with the appropriate documentation to seek re-imburement from my insurance provider. I acknowledge that *ABove Physical Therapy* is not responsible for the re-imburement of these services.

I have read the foregoing and I understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

\_\_\_\_\_ Patient or Patient Representative Signature

\_\_\_\_\_ Witness

\_\_\_\_\_ Date

\_\_\_\_\_ Date



## *ABove* Physical Therapy Policies

The policies of *ABove* Physical Therapy, LLC (*ABove* PT) are part of our agreement with you pertaining to your use of the *ABove* PT facility and equipment and your participation in any *ABove* PT activities or programs. Any change in these policies is at the owner's discretion and can occur at such time *ABove* PT sees fit. Failure to abide by these policies may result in loss of your privileges to use the facility or equipment or to participate in activities or programs and may result in loss of fees already paid. *ABove* PT enforces these policies using its discretion.

**By Appointment Only** All sessions are by appointment only. Appointments are made on a first come, first serve basis.

**Early Arrival for Sessions** It is important that clients arrive at least 5 minutes early for sessions. This will allow you to relax and prepare for your session. Our appointments are scheduled on the hour and arriving 5 minutes early helps to insure that you get a full session.

**Hours of Operation** *ABove* PT's hours of operation are by appointment only from Monday through Friday, with the exception of holidays and inclement weather. *ABove* PT may change its hours of operation as it determines necessary.

**Safe Use of Equipment** All equipment must be used in accordance with your instructor's instructions. At no time will a client be allowed to use the equipment at *ABove* PT without supervision. **FAILURE TO USE EQUIPMENT AS INSTRUCTED MAY RESULT IN INJURY TO YOURSELF OR OTHERS.**

**Return Check Fee** You will be charged \$25 for any check s returned due to insufficient funds.

**Return of Products** All fitness products, rehabilitation products and other *ABove* PT products are non-exchangeable or non-refundable

**Use of Cell Phones, & Pagers** To be courteous of other clients, please have your cell phone & pagers in the silent or off position.

**Dress Code** Please dress comfortably for your sessions keeping in mind that *ABove* PT wishes to maintain an environment where all individuals will feel comfortable exercising and receiving therapy. If you have any questions regarding the appropriateness of attire, please do not hesitate to ask your *ABove* PT personnel.

**Personal Belongings & Theft** *ABove* PT provides shelves and racks for hanging and storing your belongings. Although *ABove* PT tries to maintain a safe environment, theft can occur anywhere. *ABove* PT is not responsible for any theft or your personal belongings. *ABove* PT recommends that you leave valuable belongings at home or locked in your car. *ABove* PT is not responsible for any theft in its facility, in the parking lot or surroundings.

**Refusal of Service** *ABove* PT may refuse services to anyone at anytime. If services are refused after a purchase is made, a full prorated refund will be made upon such refusal of services (unless the refusal is due to a breach of your agreement or these policies).

**Semi-private Sessions** When you volunteer to be a partner with another *ABove* PT customer , we ask that you observe the following protocol in order to enhance the experience for you and your exercise partner:

- **Please be on time for your session** Emergencies happen, and traffic happens. But, if at all possible, please call *ABove* PT and your partner if you will be late. Your instructor prepares the session for both of you and if one party is repeatedly late, it disrupts the flow of the session.
- **If you must miss a session, let your partner know in advance** In the event of a no show by a partner, that partner must still pay for the session unless timely cancellation notice is received.
- **Private session in the event of cancellation** If one partner cancels a session in advance, the other partner may elect to have a private session for the scheduled period at the private session rate. **Cancellation Fee** In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that you cancel your scheduled appointment by phone or e-mail 24 hours in advance. This will allow us the opportunity to offer that appointment to another patient. Cancellations must be received 24 hours prior to your scheduled session to avoid being charged for the session. This fee is not covered by insurance carriers and will be your responsibility to pay at the time of your next visit. Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated as we will be strictly enforcing this policy.





## **Informed Consent For Physical Therapy Services**

Do not sign this form with out reading and understanding its contents.

Physical therapy involves many different types of evaluation and treatment. At ABOve Physical Therapy, LLC (ABove PT ) we use a variety of procedures and modalities to

address your issues and assist you in improving your function. As with all forms of medical treatment there are benefits and risks involved with receiving physical therapy.

I acknowledge that my attendance or use of the ABOve Physical Therap, LLC (ABove PT) facility and equipment or participation in any ABOve PT activities or programs could

cause injury to me. As a pre-condition to allowing me to use the facility or equipment and participate in any physical therapy activities or programs, I accept the risks associated with receiving physical therapy services at ABOve PT or with the ABOve PT equipment ("Risks"), including but not limited to the following: worsening of any medical condition or injury I might have, personal injury, theft, or contagion. I represent and warrant that my physician has prescribed the physical therapy services to be received by me, and that I have consulted with my physician about the appropriateness and safety of the physical therapy services offered at ABOve PT and on the ABOve PT equipment prior to receiving such services. I represent and warrant that I will not use the ABOve PT facility or equipment or participate in physical therapy services at ABOve PT if I possess a condition or injury that makes such use or participation inadvisable. I agree not to participate in any activities that are beyond my physical capacity.

I acknowledge and understand that, during the course of my therapy and treatment, it is likely that various types of physical therapy procedures ("Procedures") may be utilized, which are considered necessary techniques for the ordinary care and treatment of my condition(s) by my physician and/or physical therapist. While these Procedures may be routinely performed by physical therapists without incident, there are certain risks associated with each of these Procedures.

My physical therapist and physician are responsible for providing me with information about the Procedures and for answering all of my questions regarding the Procedures. It is not possible to enumerate each and every risk for every Procedure utilized in physical therapy. However, the physical therapist (in addition to my physician) providing me

services at ABOve PT has attempted to identify the most common Procedures, their risks and possible alternatives. If I have further questions or concerns regarding the

Procedures, I agree to ask my physical therapist and physician to provide additional information.

The Procedures referenced herein may include, but are not limited to, the following: ultrasound, electrical stimulation, hot packs, cold packs, ice massage, soft tissue massage, Jones strain-counterstrain, joint and tissue mobilizations, craniosacral therapy, visceral manipulation, lymphatic drainage, iontophoresis, manual traction, mechanical traction, stretching and strengthening therapeutic exercises ( including, but not limited to pilates, gyrotonic exercise, treadmill, elliptical, upper body ergometer, bike, Precore total gym and other exercises. .

I consent to and authorize the physical therapists at ABOve PT to utilize the Procedures, such as those set forth above, as they may deem reasonably necessary or appropriate in

providing me physical therapy services as they see fit in their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to treatment of all conditions which arise during the course of such Procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

By signing this form, I acknowledge and understand that I have been informed in general terms of the following;

- (a) The nature and purpose of the Procedure(s);
- (b) The material risks of the Procedures(s); and
- (c) The practical alternatives to such Procedure(s).

If I have further questions or concerns regarding these Procedures, I agree to ask my physical therapist and physician to provide additional information.

I understand that no guarantees or assurances have been made to me by ABove PT concerning the outcome and/or result of any Procedure(s).

I understand that the physical therapists providing my therapy will rely upon my documented medical history, as well as other information obtained from me (including this informed consent), my family or other having knowledge regarding me, in determining whether to perform the Procedure(s) or the course of treatment for my condition or injury and in recommending the Procedure. I acknowledge and warrant that the information that I have given regarding my medical history and current condition is accurate to the best of my knowledge.



## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Maria-Elena Bove for any additional questions you may have regarding your privacy rights. [mariaelenabovept@gmail.com](mailto:mariaelenabovept@gmail.com) or 770-904-2332.



**Above Physical Therapy Policies**

I have read and received a copy of the facility policies. I understand that failure to abide by these policies may result in loss of my privilege to use the facility or the equipment or participate in activities or programs and may result in loss of fees already paid.

\_\_\_\_\_ Initials

**Privacy Policy**

I have been offered a Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996.

\_\_\_\_\_ Initials

**Informed Consent**

I acknowledge and understand that I have been informed in general terms of the following:

- a) The nature and purpose of the procedure(s);
- b) The material risks of the procedure(s); and
- c) The practical alternatives to such procedure(s).

\_\_\_\_\_ Initials

**Missed Appointment Policy**

Your appointment time has been reserved especially for you.

- ❖ As a courtesy, we will attempt to leave you a reminder through an automated service.
- ❖ Please call 24 hours in advance to cancel or reschedule your appointment.
- ❖ A credit card number will be necessary to hold your appointment time if you have repeatedly missed appointments without notice. **A \$50.00 fee will be charged for appointments missed or canceled without 24 hour notice.**

\_\_\_\_\_ Initials

**I certify that the information I have provided is complete and true to the best of my knowledge.**

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

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

## Financial Policy

### **Insurance**

We are in network with various insurance companies and will gladly call to find out general benefits for our clients. However, we recommend to please contact your insurance company if you have questions regarding your coverage prior to your visit.

### **Co-Payments and Co-Insurance**

All co-payments must be paid at the time of service. Some plans require only your co-payment amount for office visits, but you may have an additional financial responsibility after services are rendered in the form of a deductible or co-insurance percentage. Please contact your insurance company for more specific details.

### **Missed Appointments**

Our policy is to charge for missed appointments or for appointments not cancelled prior to 24 hour notice. **There is a \$50.00 late cancellation fee.**

### **Returned Check Fee**

There is a \$15.00 fee for checks returned by the bank for non-sufficient funds.

You signature below signifies that you understand our financial policies and your responsibility regarding charges incurred in this office.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

OR

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Legal Guardian if Patient is a Minor)