



Policy & Procedures

Canceling an appointment – cannot make an appointment and notice is given with less than 24 hours notice

No Show – patient does not show up for an appointment and no communication is received prior to appointment time

- No Shows will be charged \$30.00
- 3 No Shows will result in follow up with your Doctor before being seen again
- No charge for first cancelled appointment but any cancels after that will result in a \$30 charge
- All cancel/no show fees are the patients responsibility and must be paid in full before being seen again
- It is the responsibility of the patient to obtain referrals and updated prescriptions for Physical Therapy
 - Referrals must be dated by the date of the patient's first visit
 - If the patient does not have a referral at their first visit, and their insurance requires it, the patient will be seen pending patient signature on acknowledgment of responsibility
 - If a referral still is not obtained by a patient's second visit, they will not be seen until one is obtained
 - Any visits prior to date of referral will be the patient's responsibility
- Co pays must be paid at the time of visit or settled at the end of each week
 - If co pays are not paid at end of week, patient will not be seen until balance is settled
- It is the patient's responsibility to schedule appointments
 - Appointments must be made at the front desk with the front desk staff
 - There are no standing appointments – appointments are scheduled weekly
- Verification of benefits is done as a courtesy to our patients. Patient responsibility cannot be confirmed until receipt of first insurance payment
- It is the policy of Maximum Performance Physical Therapy not to share any patient information with any outside agency for any purpose. Private patient information is used solely to secure reimbursement for rendered services. Information may be shared if a signed release from the patient/guardian has been received by Maximum Performance Physical Therapy, or if documents are requested by an authorized State or Federal Agency.

Patient/Parent/Guardian _____ Date _____