Power Up Physical Therapy & Fitness, LLC

**24 Hour Cancellation Policy**

Power Up Physical Therapy & Fitness, LLC requires 24 hours notice for the cancellation of a scheduled appointment. There is a $50 charge for a No-Show or cancellation without proper notice. This charge will not be covered by your insurance. I understand that extenuating circumstances may occur which is why I have implemented a “one strike” policy. I will allow one cancellation before charging the $50 fee. A No-Show will automatically be charged the $50 fee. Maintaining regular treatment sessions is essential for positive outcomes. Repeated no shows or cancellations will hinder your care and may result in discharge from this clinic.

This policy is in place out of respect for the therapist and all of my clients. Cancellations with less than 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot, and leave a 60 minute hole in my schedule.

1. Please provide the therapist with 24-hour notice to change or cancel appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 service charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.
2. I reserve your 45-60 minute session appointment time just for you. I do not double book any patients so that I can provide optimum treatment outcomes for all of my patients.
3. After two missed or cancelled appointments without the appropriate 24 hour notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

*You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time.*

*Thank you for providing myself and my patients with this courtesy.*

*I have read, understand, and agree to abide by the policy above:*

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Responsible Party) Date