KANSAS ORTHOPAEDIC CENTER P.A.
THERAPY DEPT

CONSENT FOR TREATMENT

Patients Name: _____ Date _____

MR# _____

I hereby authorize the therapists at this clinic to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

(Authorized Signature) (Date)

Cancellation/No-show Policy:

I understand the importance of attending therapy consistently and arriving promptly for my dedicated appointment time. I acknowledge that I may be rescheduled if I arrive more than 10 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $25. I understand that if I cancel and/or no show 3 consecutive appointments the therapist has the right to cancel all remaining appointments made and discharge therapy.

WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjustor and/or Rehabilitation Manager of all missed, canceled, or rescheduled appointments. It is also required that all missed visits be rescheduled.

_____ _____

Initial Date