

***Lighthouse Physical Therapy, LLC***  
**CANCELLATION POLICY**

When you are scheduled for a treatment session at Lighthouse Physical Therapy, the time is reserved especially for you. When you cancel without proper notification (see below) or if you do not show up for your scheduled session it makes it difficult for us to maintain a consistent schedule for our therapists and for those patients who are on our waiting list wanting to be scheduled.

You must **notify our front office (not the therapists)** of your cancellation. You may call and leave a message anytime during or after our regular business hours, the answering machine will record the date and time of your call. If you should fail to cancel within the appropriate time schedule listed below there will be a **charge of \$75 (fee doubles for two hour appointments to \$150)**. **You (not your insurance company) will be responsible** for payment of this charge and it must be paid within 30 days or prior to your next appointment (whichever occurs first). We understand that circumstances beyond your control may arise and will take them into consideration (ex: sickness, family emergencies, accidents, etc.).

In addition, if you miss 2 appointments without calling to notify Lighthouse Physical Therapy and/or fail to reschedule or return our call, we reserve the right to discharge you from physical therapy and you will need a new referral from your doctor to continue physical therapy.

**1 hour appointment      Cancellation minimum 24 hours advance notice**

**2 hour appointment      Cancellation minimum 48 hours advance notice**

We regret having to implement this policy, however due to the high rate of last minute cancellations and patient “no-shows” it has become necessary that we make this change. We value all of our patients and we hope you will understand that in the interest of fairness it is important to have advance notice of cancellations so that those spots may be used by other patients. Thank you for your understanding.

I have read, or have had it read to me, and understand the information on this form. I have had an opportunity to ask questions and have had them answered to my satisfaction. I agree with the conditions set forth.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Parent/  
Legal Guardian if patient under 18

<u>For Office Use Only</u>		
Signed copy given to patient:	_____ Yes    _____ No	Date given: _____
_____		
Staff Signature:	_____	