ELEVATION
PHYSICAL THERAPY

Patient Responsibilities

1. **<u>Pay your cash payment or co-insurance at each visit</u>:** Payments are due at the time of your appointment or you can pay at the beginning of the week or month for all your appointments ____ **(initial)**

2. **<u>Cell Phones</u>:** Please turn off your cell phone when you enter the building as a courtesy to the therapist and the other patients _____ **(initial)**

3. **<u>Cancelled Appointments</u>:** Appointments cancelled day of the appointment will be charged a $35 cancellation fee. "No shows" will be assessed the full per session amount. If appointments are cancelled or changed at least 24 hours in advance, no fee will be assessed. _____ **(initial)**

I have read and understand the above policies.

_____ _____ _____

Print Name Signature Date