REVOLUTION
REHABILITATION P.C.
PHYSICAL, ORTHOPEDIC & SPORTS THERAPY + WELLNESS

Telephone Consent:

The Practice contacts Patients for a variety of reasons, including appointment reminders and providing test results. If you would like to restrict the way in which we contact you (e.g., do not leave messages on phone message machines or other recorders; do not provide information to others who may answer your phone (at your home or office), please inform a member of our reception desk staff and complete the following form.

PATIENT INSTRUCTIONS TO THE PRACTICE'S STAFF REGARDING TELEPHONE CONTACT:
Patient Name ____

It is permissible to **contact me/leave a voice message/leave messages with other people** at the telephone below:

Telephone Number: (____) _____ - _________
CAN WE EMAIL YOU STATEMENTS YES______ NO______
EMAIL ADDRESS__________________________________

NO SHOW/CANCELLATION POLICY:

We understand that circumstances may arise that prohibit you from attending your appointment; however, we require a **24 hour notice** if you need to change, or cancel your appointment. Please be advised that a **$35 cancellation fee will be enforced without a 24 hour notice.**
A $35 fee will be charged if you no show for your appointment.

This fee will be collected at the time of your next visit, unless arrangements are made. Failure to pay this fee may result in a Collection Agency recovery, service fees, and interest charges.

If there are consecutive or frequent cancellations/no-shows despite a 24 hour notice, it is at the discretion of the treating clinician and or practice manager to determine if you will be discharged from the practice.

You may leave a message at any time, or send us an email at info@revrehab.com if you need to cancel or reschedule your appointment.
I understand, and acknowledge this policy and accept financial responsibility for the above.

Printed Name: ___________________ **Signature:** ________________________**Date**___________

HIPAA

I have also been informed of, and given the right to review and secure a copy of the Revolution Rehabilitation, P.C. Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Revolution Rehabilitation, P.C. reserves the rights to change the terms of this notice at any time and that I may contact Revolution Rehabilitation, P.C. at any time to obtain the most current copy of this notice. I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

Printed Name: ___________________ **Signature:** ________________________**Date**___________