

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: (____) _____ - _____

MEDICAID NO SHOW/ CANCELLATION POLICY

We understand circumstances may arise that prohibit you from attending your appointment; therefore, we appreciate a **24 hour notice** if you need to change or cancel your appointment.

Medicaid patients are **allowed one missed scheduled appointments**. Any missed appointments **thereafter will result in a discharge from the practice**, and a letter of your discharge and/or non-compliance will be sent to your referring provider and Health First Colorado (Medicaid). This may affect your future benefits for PT/OT.

You may leave a voice message at any time, or send us an email at info@revrehab.com if you need to cancel or reschedule your appointment.

****Please notify us if you have had any therapy sessions prior to this visit. It impacts your eligibility.*

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** _____