

PATIENT COMPLIANCE FORM

Welcome to Choice Therapy. We look forward to assisting you in your recovery process. In order to maximize the effects of your treatment please follow the requirements below:

- 1. Show up on time.** We schedule adequate amounts of time for us to successfully complete each visit. If you show up late, the therapist reserves the right to shorten your treatment session or even cancel your visit altogether if you are late by 30% or more of your appointment time. Showing up late may negatively impact someone else's treatment as well.

Patient Initials: _____

- 2. Avoid cancellations.** Failure to attend each session, by cancelling or not showing up compromises your therapist's ability to help you get better. If you are unable to attend your scheduled appointment, please give 24 hour notice. If treatments are cancelled 2 times or if there is 1 no-show, your therapist may modify or discontinue your scheduled appointments. Please be aware that this may negatively impact your rehabilitation process.

Patient Initials: _____

- 3. Follow the directions provided by your therapist.** As part of your care your therapist may give you a number of exercises to do at home. Your therapist may also give you additional instructions that you need to follow throughout your treatment phase. Not complying with these directions may negatively affect the outcome of your rehabilitation.

Patient Initials: _____

If you are able to fully comply with these guidelines your therapist will be able to better assist you in returning to your previous level of function. Your therapist will do everything possible to greet you at your scheduled appointment time, however, we may be a few minutes late due to other patient's treatment sessions that may overlap. Please be accommodating as your therapist is committed to giving you the necessary time and attention that has been given to the patients that were scheduled before you.

Thank you so much for complying with these guidelines. As stated, these instructions have been put in place to provide effective, quality care for you and other patients.

I have read, understand, and agree to comply with this policy.

SIGNATURE: _____

DATE: _____