**Solana Beach Physical Therapy**

530 Lomas Santa Fe Dr Suite G

Solana Beach CA 92075

**Cancellation and No-Show Policy**

At Solana Beach Physical Therapy we believe that our time together is valuable. We pride ourselves on giving you a one-on-one, individualized session for a high quality physical therapy experience. In order to provide this level of care, it is important that we are notified **at least 24 hours** before your appointment time in the event of a cancellation. Not showing up to a scheduled session without notifying our office is considered a “no-show.” This is detrimental to a patient’s plan of care and will not be tolerated without a financial penalty.

If a cancellation is made with less than 24 hours notice, or in the event of a no-show, a $50.00 cancellation fee will be charged to your account. We regret that we cannot make any exceptions.

I agree to these terms and conditions listed above.

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list credit card information below. This information will be kept confidential and we will only charge your card in accordance with our cancellation and no-show policy or to process your co-pays.

Type of card (Circle one): Visa MC AMEX DISCOVER

Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exp. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3 digit code on back: \_\_\_\_\_\_\_\_\_\_\_

Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SBPT Patient Consent Privacy Practice (HIPPA)**

By signing this consent form, I (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorize this office to use and disclose information from my medical records (Protected Health Information) for the following purposes:

* Voice calls, sending texts, or e-mails to remind me of an appointment, change in appointment, or schedule a new appointment
* Calling me to discuss test results or treatment options
* Sending me newsletters or cards (birthdays, holdays, get well, etc)
* Informing me about new services or special events that occur at this office

Phone calls or texts will be made to the most recent number in our records. We will speak with anyone who identifies himself or herself as our patient or patient’s parent or legal guardian. Please help us stay current with our information by letting us know of any changes in name, address, insurance, or phone numbers.

I HAVE READ AND UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION WILL BE USED AND I AGREE TO THESE POLICIES AND PROCEDURES.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_