

**ATTENDANCE POLICY**

**Cancelation and No Show policy:**

Patients are expected to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is expected to give 24 hours advance notice by calling the office at (970) 241-5856 or may be charged a cancellation ***fee of $50.***  Your insurance does not cover this fee. Payment of these fees are required prior to future visits.

Two (2) appointment no-shows and/or unexcused less than 24 hour cancelations may result in discontinuation of the current appointment schedule for the therapy involved.

A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services.

Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on “hold” for a determined appropriate length of time. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

We do offer text/email reminders as a courtesy, however it remains the patient responsibility for all scheduling.

**Late Policy:**

We strive to see you on time. Please arrive 10 minutes prior to your appointment to ensure adequate time for the check in process and be ready to start your therapy session at your scheduled time. If you arrive more than 10 minutes late for your scheduled time, your appointment may be shortened or you may be asked to reschedule.

**Children:**

All children ages 15 years and younger must remain accompanied on campus by an adult while in the clinic.

**Illness:**

If you are feeling ill, please contact our office to reschedule your appointment.

**We understand that there are extenuating circumstances that can jeopardize your on time arrival and attendance. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.**

**Our staff will work with you to ensure continued care if you experience events that are beyond your control.**

Patient Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature (if patient is under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Updated 9/2023