GENUINE
rehab wellness

Dear Valued Genuine Rehab & Wellness Patient,

At Genuine Rehab & Wellness, we are dedicated to the treatment of the whole patient, not just the illness. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for one-on-one therapy. When a patient fails to show up for an appointment or to cancel within 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control. In this event, we ask that you call our office and cancel your appointment within at least **4 hours** of the scheduled visit, or a **$25 missed appointment fee** will be incurred. This courtesy allows the office staff to try and schedule another patient who is also in need of physical therapy care.

We appreciate you entrusting us with your health care needs. Please reach out with any questions or concerns regarding this matter.

Yours in Health,

The Genuine Rehab & Wellness Team

_____

I have read and agree to the $25.00 missed appointment fee without a 4 hour cancellation notice.

_____
Printed Name

_____ _____
Signed Name Date

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Credit Card Authorization Form

We understand that things in life do come up; however, we ask that if you need to cancel an appointment you make every effort to notify us at least 4 hours prior to the appointment. There will be a $25 fee charged to the credit card on file for any late cancellations or no shows.

Name on Card: _____

Billing Address: _____

City _____ **State**_____ **Zip Code** _____

Credit Card Type: _____ Visa _____ MasterCard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____ **CVV Number:** _____ (last 3 digits located on the back of the credit card)

I, _____, authorize Genuine Rehab & Wellness to charge my credit card above for the agreed upon $25 cancelation fee. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date