

Patient Name: \_\_\_\_\_



LANCASTER PHYSICAL THERAPY  
& SPORTS MEDICINE

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### THERAPY PARTICIPATION

We ask that all patients give 24 hours notice for appointment cancellations. Patients will be given appointment cards for scheduled appointments. These cards contain their physical therapist name, Lancaster Physical Therapy & Sports Medicine's address and telephone number to contact us. **Please do not cancel appointments via email.** Failure to provide 24 hours notice or a "no-show" appointment will result in a \$25.00 fee.

Our therapist time is valuable as well as our patients. Our goal is to help our patients to reach the goals set by the therapist during the patients' initial evaluation. Our therapists are committed to helping our patients reach these goals; however, we can only work towards these goals with you attending your appointments.

Patients who fail to show for two consecutive appointments or cancel and / or no show 3 consecutive appointments will be discharged and asked to return to their physician before returning to physical therapy. A note will be sent to the referring physician regarding the patient's attendance.

Appointments may be made in advance; however, if attendance is not consistent advanced appointments may be limited.

**Signature below acknowledges Patient or Patient Representative has read all information above.**

Patient or Patient Representative Signature:

\_\_\_\_\_  
*(Patient Representative required if the patient is a minor under 18 or an adult who is unable to sign this form)*

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

Relationship of Patient Representative to  
Patient: \_\_\_\_\_

Reviewed by (Staff Initials) \_\_\_\_\_