ADVANCED KINETICS
physical therapy + sports performance

Appointment Cancellation Policy

At ***Advanced Kinetics Physical Therapy,*** we strive to provide each patient with the highest quality of care. Your consistent attendance of the outlined treatment plan is paramount to your full recovery.

Any cancellation given within two business hours before a scheduled appointment will be charged a cancellation fee of $100

i.e. This charge will be applied for a 7 am appointment if the cancel is after 5pm the previous day

Any Cancellation notice within our 24-2 hour policy will result in a Fee of $50

Any Cancellation received via email will not be accepted and charged as a no show fee of $100

No Shows will be charged $100

Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you and our other patients. Missed appointments prevent other patients from coming in at the same time and affect the consistency of your own rehabilitation program. As a result, **3 late cancellations or no shows will result in discontinuing physical therapy at AKPT**. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge from physical therapy.

All phone messages received for cancellations are recorded in a timely fashion in our computer system with a time and date stamp. You may dispute charges in writing to AKPT should you disagree.

_____I understand that the card, including FSA, HSA or any flexible spending card that I have provided below can be used to cover any remaining balance on my account after discharge, excluding any cancellations or no shows.

_____I understand that any cancellation or No Show fee can NOT be submitted to my insurance for reimbursement. Therefore, I understand that the second form of payment information provided will cover any balances or charges that are remaining on my account.

Please provide Credit Card information for any balance, copay or coinsurance:

Credit Card #:_____Exp. Date:_____

Name: _____CVV _____

Please provide the card information that will be used for any cancellation or no show:

Credit Card #:_____Exp. Date:_____

Name: _____CVV _____

I understand Advanced Kinetics Physical Therapy's appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify AKPT appropriately if I have difficulty fulfilling my scheduled appointments.

Patient Signature _____Date _____