



## THERAPY GUIDELINES

- ✓ Welcome to Spectrum Rehabilitation. In order for you to obtain optimal benefits from your treatment program, it is essential that you attend each scheduled visit. You will not gain maximum benefit from your therapy without consistent follow-up and treatment; this could delay your recovery. **A parent or guardian must accompany a minor on the initial visit.**
- ✓ The frequency of your appointments is determined by your physician and therapist based upon your injury. **Please allow at least one hour for your initial visit and wear loose, comfortable clothing.** (A sports bra for females may be more comfortable, shorts are helpful for knee and back injuries.)
- ✓ Appointments should be scheduled at least one week in advance. If you cannot keep your scheduled appointment, **please call at least 24 hours in advance to cancel and reschedule. If you are 15 minutes late for an appointment or if you fail to attend a scheduled appointment without previously cancelling/rescheduling, you will be considered a “no-show”.**
  - If you are a Workers’ compensation patient, your employer and adjuster will be notified that you did not attend your scheduled therapy visit.
- ✓ It is our clinic’s policy that 3 no-shows and/or cancellations may result in cessation of therapy and the need to consult with your physician prior to resuming therapy. **It may also result in a no show fee of \$35 being applied to your account.** If your employer insists on keeping appointments during non-working hours, inform us of this on your first visit, so we can accommodate your schedule.
- ✓ Alcohol and non-prescribed substances are not allowed on the premises. If you have been drinking alcohol or using non-prescribed drugs before your treatment, you will not be allowed in therapy.
- ✓ For safety reasons, children, other family members, or friends are not allowed in the treatment areas but are welcome to have a seat in our waiting area. We regret that we are not able to accommodate children who require supervision. For their own safety, please make alternative plans.
- ✓ Please, understand that payment is due at the time of service unless other arrangements have been made.
- ✓ *I agree to pay all co-payments required, any required deductible, and any other amount due that my insurance will not pay. If this account goes to collections, I understand that I will be responsible for all fees incurred, including any attorney’s fees. I authorize the release of information necessary to process my insurance claims and to facilitate communication with my physician and payer source. I authorize payments to be made directly to Spectrum Rehabilitation.*

**I UNDERSTAND AND AGREE WITH THE ABOVE GUIDELINES TO PARTICIPATE IN MY RECOVERY.**

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

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