

Important Information

Carnahan Therapy..... Patient Policies and Responsibility Agreement

We believe in the best possible outcome for you! To achieve this you and your therapist must agree to accept responsibility with your program and communication.

- We understand that your time is valuable, please understand that our time is valuable too. We set aside professional staff time and equipment to provide you with customized care.
- It is important that we see you as scheduled. This optimizes your recovery. Missing appointments can result in a negative outcome for you.
- Please call if you can't make your appointment, it gives us a chance to fill your time with another appointment.

Scheduling

- Scheduling your appointments in advance allows you to plan other activities around your therapy. If you need to make a change later we will accommodate the change.

Cancellations

- If you must cancel an appointment plan to reschedule in the same week.
- Many insurances now request attendance records to determine your therapy authorizations. Call with your reason for cancellation.

No-Shows

- Failure to show up for an appointment is considered a breach in your responsibility as a patient and is disrespectful to your therapy team. Calling is the right thing to do. After 2 no-shows you will be removed from the schedule and your referring physician notified.

Cell Phones

- Please silence them while in clinic as a courtesy to your treating staff and the other patients in the clinic.
- If you must take a call, inform the staff at the beginning of treatment.

Visitors

- We have limited space to accommodate visitors with the patients. It can also be disruptive to other patients. If you have a special need discuss it with staff.

Arriving Late or Early

- If you arrive late we may have to adjust your treatment to avoid impact to the patient scheduled after you.
- If you arrive early you may have to wait until your team is available.

Informed Consent

You will be informed by your treatment staff regarding the treatments being provided to you. The risk and benefits will be discussed, as well as any other information you request. Please elect your choice regarding this consent:

_____ I decline to be informed.

_____ I want to be informed about the program details.

Date _____

Patient Signature _____

Therapist Signature _____