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### **Cancellation/No Show Policy**

In order to have the chance to gain successful results from physical therapy here at Leading Edge, there not only needs to be a skilled and effective physical therapy team present, but there also needs to be a commitment and a responsibility from you, the patient to attend all scheduled therapy sessions (except in emergency situations). We, here at Leading Edge hold ourselves to a high standard and choose to respect our patients by seeing them on time for appointments.

The staff is dedicated to accommodating your scheduling requirements to the best of our ability. In exchange, Leading Edge expects and requires all patients to reschedule or cancel BY 3PM the day before the scheduled appointment. Any appointments that are not rescheduled or cancelled by 3pm the day before will be assessed a **\$25** cancellation/no show fee for week day appointments, and a **\$50** cancellation/no show fee for Saturday appointments. Remember, these same fees will be applicable to appointments where patients do not show up and do not call. Also, if you miss more than 3 appointments, we reserve the right to discontinue your treatment with us.

If you are Workers' Comp, we are required to immediately notify your case manager and doctor if you are either late or miss your appointment.

Please be on time for your appointment or it can decrease your therapy time. If you arrive more than 15 minutes late, there is a chance your appointment may have to be rescheduled.

Please remember, the clinic sets time aside especially for your appointment and without the appropriate notice, we cannot provide the chance to another patient to come in who may have needed that same time. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask if you have any question about our fees, Office Policy, or your responsibility.

Thank you in advance for your understanding.

Sincerely,

The Leading Edge Staff

**I HAVE READ THE CANCELLATION/NO SHOW POLICY AND UNDERSTAND MY RESPONSIBILITY TO PAY A CANCELLATION/NO SHOW FEE OF \$25 FOR WEEK DAY APPOINTMENTS, AND \$50 FOR SATURDAY APPOINTMENTS IN ACCORDANCE WITH THE POLICY ABOVE.**

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_