PT Link Good Faith Agreement

I agree by my signature on this good faith agreement, that I will maintain the treatment schedule prescribed by my doctor and physical therapist. The criteria by which I may be discharged and/or may incur a fee for non-compliance are as follow:

- **Three (3) cancellations will be cause for discharge**
- **Three (3) no- shows will be cause for discharge**
- **Also, your referring doctor will be notified of your non-compliance**
- **Any exceptions to these criteria will be handled by the therapist on a case-by-case basis**

24-hour notice must be given for all physical therapy visits

- **$25.00 for a missed office visit with a physical therapist/physical therapist assistant**

You must make payment immediately when a no-show cancellation charge has been assessed to your account in order to schedule any appointments or to avoid cancellation to other appointments previously scheduled.

Physical Therapy is very important to you, your therapist and your physicians. So, keeping all of your appointments are essential.

Patient Signature: ____ Date: __________________