Integrity Therapy Group, L.L.C.

NO SHOW / CANCELLATION POLICY

INTEGRITY THERAPY GROUP
416 N SEMINARY STREET, SUITE 100
FLORENCE, AL 35630

At Integrity Therapy Group we believe that a good relationship with our patients, based on communication and understanding is crucial to the healing of all our patients. Thank you for trusting your medical care to Integrity Therapy Group. When you schedule an appointment with Integrity Therapy Group we set aside enough time to provide you with the highest quality care and make sure we have adequate staffing to care for your needs. Should you need to cancel or re-schedule an appointment, please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This will give us time to schedule other patients who may be waiting for an appointment that may have been unable to schedule.

Please see our No Show /Cancellation Policy below:

After 2 no shows or Less than 24 hour notice:

Effective 5/1/23 any established patient who fails to show or cancel an appointment and has not contacted our office with at least 24 hour notice will be charged a $25.00 fee

After 2 no shows or cancellations less than 24 hour notice and upon discretion of your physical therapist dismissal from Integrity Therapy Group could occur.

The fee is charged to the patient, not the insurance company and is due at time of patient's next office visit. Please see front desk as you check in to pay.

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office manager, Karen Anderson, (256) 764-1442 who **may** be able to waive the fee under certain circumstances.

I have read and understand Integrity Therapy Group's No Show/Cancellation policy and agree to its terms

_____ _____

Signature (Patient or legal guardian) Relationship to Patient

_____ _____

Printed Name Date

For office use only: _____ (chart #) _____

Staff Member Witness Signature