Thunder Bay Therapy
& Sports Medicine

Notice and Acknowledgement

Acknowledgement:

I acknowledge that I have been given access to the Notice of Privacy Practices for this clinic. I have the right to receive a copy of this Notice from the front desk at any time.

_____ ____/____/____
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

Cancellation and NO-Show Policy

We require 24 hours notice in the event of a cancellation. We understand that emergencies do come up and would appreciate a call as soon as possible to reschedule your appointment. **If you do not call to cancel or reschedule your appointment, you may be charged $20.00 for failure to show. This charge will not be covered by your insurance company; therefore, you will be billed directly.** Please be prepared to reschedule your appointment at the time you call. Thank you for your cooperation.

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