POLICIES AND AUTHORIZATIONS

MASONIC HOMES KENTUCKY

Cancellation and No Show Policy

Consistent attendance allows you and your therapist(s) to progress your treatment program resulting in quicker recoveries and better outcomes. It is important that you attend all scheduled therapy appointments. If you cannot keep a scheduled appointment, notify your therapist of cancellation or need to reschedule at least 24 hours prior to the scheduled appointment. The charge for cancellation without proper notice is $25. This charge will not be covered by insurance but will have to be paid by you before any additional treatment is received. Three consecutively missed appointments by cancellation or as few as one missed appointment by "no-show" may subject you to consideration for discharge. If you consistently miss scheduled appointments, the therapist will consult with your physician regarding the potential need for discharge from therapy. NON-SUFFICIENT FUNDS: Check returned for Non-Sufficient funds may be subject to a $25 processing fee. I have been informed, understand and acknowledge the Attendance Policy.

Patient signature: _____ Date: _____

Permission to Leave a Detailed Message

Do we have your permission to leave a detailed message on your answering machine / voicemail with a family member or a legal representative regarding appointments, billing or other matters regarding your treatment?

☐ Yes ☐ No Other (please specify) _____

May we call you at work? ☐ Yes ☐ No

I authorize Masonic Homes Kentucky to disclose my health information that is directly related to my current treatment to the individual(s) listed below for purposes of their role in my treatment or payment for the health services I have received. Such persons involved in your care may include spouses, children, blood relatives, roommates, domestic partners, neighbors and colleagues.

Name	Relationship

Acknowledgement of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices

Print patient's name: _____ Date: _____

Patient or personal representative signature: _____

If personal representative's signature appears above, please describe personal representative's relationship to the patient: _____