



WELLSPRING THERAPY
The source for healing

500 W. Glenoaks Blvd., Glendale, CA 91202-2813
3700 Park Place, Montrose, CA 91020

Tel: 818-637-2127
Tel: 818-249-8815

Fax: 818-637-2126
Fax: 818-249-8814

Cancellation and No-Show Policy

We strive to provide our patients with the highest quality of care and service. We are committed to your wellbeing—and the restoration of your physical abilities is something that everyone in our clinic takes seriously.

Because we care very much about you, we emphasize the importance of your own commitment to therapy. We know from experience that this is essential for your recovery.

Your adherence to the recommended number of treatments is a vital component of your progress. Thus we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep *all* your appointments. *Write down the time of your visits so that you do not forget.*

With the exception of serious emergencies, it is expected that you will keep all your appointments. If you need to re-schedule an appointment, we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

There is a \$50 charge for a no-show or cancellation without 24-hour notice. The charge will not be covered by your insurance, but will have to be paid by you personally. We will also require a credit card number on file to reserve your next appointment, and we will charge your credit card for any future cancellations without proper notice.

If you are late for your appointment, we will try to accommodate you. However, you may not receive full treatment as scheduled.

For Worker's Compensation and Personal Injury patients, we are required to forward documentation of any missed appointments to your case manager and primary physician. This could jeopardize your claim.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and to inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read and understand this policy: _____
Patient Signature

Date: _____