FUNCTIONAL MECHANICS, LLC

1050 Waltham Street, Suite 330 · Lexington, MA 02421

Dear Patient,

As in all busy practices, we find it necessary to have policies and procedures that enable us to provide the best care and make the benefits of our services available to as many people as possible. Please read the following carefully and let us know if you have any questions. Thank you for your cooperation.

Scheduling Guidelines

1. Your clinician has set aside specific appointment times. Please be sure to schedule your appointments in advance. Please **ARRIVE ON TIME** for each appointment, unless otherwise specified by your clinician. **If you are more than 15 minutes late, it may be necessary to reschedule your office visit.**

2. **IF YOU NEED TO CANCEL YOUR APPOINTMENT** please notify us within 24 hours. Try to reschedule your appointment as soon as possible. Excessive cancellations can affect your continued care with us and may result in discontinuation of care. Please discuss with your clinician any issues that may be out of the ordinary.

3. A **"No-Show"** is when you have given no prior notification for your absence. You will be billed for **No-Show** appointments. Excessive "**No-Show's"** will result in discontinuation of care.

4. Please come 15 minutes early for your **Initial Visit** to complete necessary paperwork. If you were referred by a doctor, please make sure you bring your **PRESCRIPTION** and a copy of any diagnostic tests such as **X-Rays, MRI, EMGs or other tests including radiology reports**. Please bring a copy of your **OPERATIVE REPORT** if you are being seen following surgery. If you were referred by another healthcare provider, please make sure you bring any paperwork they gave you. If you are uncertain, please call to clarify.

5. Please come **PREPARED** for all follow up office visits with whatever your clinician has directed you to bring, i.e. specific footwear, socks, shorts, etc. If you are uncertain, please call to clarify.

6. **IF YOU HAVE PLANNED A VACATION,** or anticipate the need to have services provided with a very specific window of availability, please schedule your office visit **as soon as possible**.

Confidentiality

Any information regarding you and your care will be kept confidential. If you have been referred by, or are under the care of, a healthcare provider for the current condition you are here for; we need your permission before we can communicate or share any information with them.

☐ Yes, you have my permission to communicate and share documentation with:

☐ No, you do not have my permission to communicate and share documentation with:

Fees

We are a private-pay practice, as such; you are responsible for payment of all and any fees at the time of service. Foot orthotics, footwear modifications and/or any products that you choose to purchase are not returnable or refundable. No-show appointments and cancellations occurring less than 24-hours before the appointment will result in a no-show fee, which you are responsible to pay within 30 days.

I HAVE READ AND UNDERSTAND THE ABOVE

Patient: (print name) _____ (signature) _____Date:_____

Clinician: (print name) Cheryl L. Maurer, PT, MS, C.Ped. (signature) _____Date:_____

Edited: 1/9/13