

RESTOR Physical Therapy @ Shoreline  
 1235 Pear Ave Ste. 101  
 Mountain View, Ca 94043  
 650.965.8434  
 Fax 650.965.8545

**Confidential Channel of Communication Request**

*As required by the Health Information and Accountability Act (HIPAA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. This includes communicating with any doctor's office and retrieving all records and reports related to your condition. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.*

I, \_\_\_\_\_ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment, or payment for treatment. **This request precedes any prior request for confidential channel communications I may have made.**

Please list the best phone number to reach you at: (\_\_\_\_)\_\_\_\_\_

Yes	No	Please check all that apply:	Specific Information:
		May we leave a message on your answering machine?	
		May we leave a message with any other person?	If yes, specific person name:
		Is it ok to discuss your diagnosis and treatment with your family members?	If yes, specific person name:
		Would you like to receive health articles via e-mail from Restor Physical Therapy?	If yes, e-mail address:
		Have you received the notice of Privacy Practices? Available at front Desk.	

**Cancellation/No Show Policy**

**Private Insurance and Medicare Patients:**

Any no show or cancellations that are not made **24 HOURS prior** to you scheduled appointment time are subject to a \$120.00 cancellation fee, which will be billed to your account.

**Workers Compensation Patients:**

Any now show or cancellations that are not made **24 HOURS prior** to your scheduled appointment time are subject to a \$120.00 cancellation fee, which will be billed to your account. Workers comp will not be responsible for cancellation or no show appointment fees. All cancellations will be reported to your Workers Comp. Insurance adjuster.

**Cell Phones**

As a courtesy to others, cell phone use is strongly discouraged during all treatment sessions. We ask that you please turn your phone off, or set it to silent mode before your appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

If not signed by the patient, please indicate relationship: \_\_\_\_\_

Name of patient: \_\_\_\_\_