



Cancellation Policy

I understand that a \$25.00 fee will be assessed for each appointment that I schedule but do not attend, or that is rescheduled with less than 24 hour advance notice. Goddard Orthopedic & Sports Therapy, Inc. reserves the right to waive such fees as a courtesy in the event of severe weather, health emergencies and special circumstance. This fee is not reimbursable by your insurance carrier.

Authorization for Medical Information Release

I authorize Goddard Orthopedic & Sports Therapy, Inc. to furnish my insurance company with medical information they may request regarding my condition or treatment. Furthermore, I authorize my referring healthcare provider to release any diagnostic reports and/or surgery reports to Goddard Orthopedic & Sports Therapy, Inc.

Privacy Notice & Patient Bill of Rights

I have read and understand Goddard Orthopedic & Sports Therapy, Inc. Privacy Notice and Patient Bill of Rights.

I certify that I am 18 years of age and/or the legal guardian/guarantor of the patient named below.

Printed Name of Patient: _____ **Date:** _____

Signature of Patient and/or Legal Guardian: _____