

Out of Hospital DNR and Attendance Policy



Out of Hospital DNR

This is a legally binding order in the form specified by the advance directives act that documents the instructions of a person or person's legally authorized representative and directs healthcare professionals acting in an Out-of-hospital setting not to initiate or continue certain life-sustaining treatments. **(DO NOT RESUSCITATE)**. If you have an out of hospital DNR, we need to be aware of this and have a copy for your medical record. If you want more information about this, we can refer you to our case management team.

Do you have an out of hospital DNR? Yes No

Copy received and placed in chart? Yes No

Outpatient Coordinator Signature: _____

Patient's Signature: _____

Attendance Policy

It is our goal at Post Acute Medical to be able to schedule patients as quickly as possible into our schedule. We are asking for your cooperation in notifying us of any appointments that you will not be able to keep in order for us to be able to utilize these openings for other patients.

CANCELLATION POLICY: When you know that you will be unable to keep a scheduled appointment, please make every effort to call us a day in advance to reschedule the appointment, or to cancel your appointment.

There is a missed appointment fee of \$25.00 if we have less than 24 hours' notice of a cancellation of an appointment, or if you do not show up for a scheduled appointment.

Three (3) cancellations and/or No Shows (no phone call prior to scheduled appointment) in a 30 day period is cause for discharge from therapy. Your physician will be notified of your discharge. If you wish to resume therapy, you will need to obtain a new prescription from your physician. Please arrive for your therapy session(s) on time. If you are late, your session will be reduced to the amount of time remaining in that scheduled session.

Post Acute Medical is dedicated to helping you reach your rehabilitations goals. Your attendance and participation in therapy is the key to your recovery. Thank you for your time and consideration.

Patient Signature

Date