Account:

University of Wisconsin
Rehabilitation Clinics
6630 University Avenue
Middleton, WI 53562
608-263-8412 Phone
608-263-5011 Fax

OUTPATIENT ATTENDANCE

Our goal at University of Wisconsin Hospital & Clinics is to offer the best possible care to our patients. We want to work with you to make that happen. To best work as a health care team we need your cooperation on the following.

1. **Attendance:** We understand situations happen which make it impossible for you to keep a scheduled appointment. If this happens, please call us as soon as you know the appointment will be missed. The earlier you let us know, the more likely we can offer your scheduled appointment time to another patient. Please call us at 608-263-8412 so we can reschedule the appointment for a date and time that will work for you. Missing appointments decreases your success with therapy. If you miss three appointments, you may be discharged.

2. **Timeliness:** If you are more than 15 minutes late, we may ask you to reschedule your appointment.

3. **Insurance:** You will be responsible for visits and charges that your insurance company does not cover. Please contact the customer service department of your insurance company for accurate information regarding your physical occupational, and or speech therapy benefits.

I have read the above policy.

Signature

Date

Account:

University of Wisconsin Hospital and Clinics
600 Highland Avenue • Madison, Wisconsin 53792

UW HEALTH REHABILITATION CLINIC
PHYSICAL/OCCUPATIONAL/SPEECH THERAPY

Please complete this form so we have the most up to date information to facilitate communication with you and your community agency.

Name: ______________________________

Phone # I prefer to be contacted at:

☐ Home ______________________________

☐ Work ______________________________

☐ Cell Phone ______________________________

Primary Care Physician: ______________________________

Emergency Contact Person: ______________________________

Phone: ______________________________

Please complete if using a transportation service

Transportation Service: ______________________________

Phone: ______________________________

Please complete if you are receiving services from a community agency (Care Wisconsin, Senior Centers or Coalitions, etc.)

Contact Person: ______________________________

Phone #: ______________________________

What do you wish to accomplish with Therapy? What are your goals?

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