

**UF Student Health Care Center**  
**Physical Therapy Services**  
Provided by UF HEALTH REHAB CENTER  
**Information Acknowledgement Form**

Name: \_\_\_\_\_ UFID/MR: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Type of insurance coverage: \_\_\_\_\_

We look forward to providing physical therapy for you and we need your full participation in order for you to achieve the maximum benefit from therapy.

1. Please arrive on time for your scheduled appointment. Please call if you will be more than 10 minutes late. If you are more than 15 minutes late for your appointment, we may be required to reschedule. If you arrive late and are seen, your appointment may be shorter than normal as to not disrupt the patients who are scheduled after you.
2. Please call at least 24 hours in advance if you know you have to cancel an appointment. We understand emergencies happen, so in these instances please call as soon as possible to cancel your appointment.  
**Phone number: 352-294-3065**
3. We will have to remove you from our schedule after 2 "no-shows" or 3 cancellations. This may require you to return to your doctor before coming back to therapy. Your doctor will be made aware of cancellations and "no-shows".

The Physical Therapy clinic at the University of Florida is a teaching environment. Students may be involved in your treatment at this facility. If you do not wish to have one of our trained students working with you, it is **YOUR** responsibility to notify the therapist so that special arrangements can be made for your treatment.

**STUDENTS ONLY:** Please be advised that Physical Therapy charges incurred are **NOT** included in the Student Health Fee. Physical Therapy services are a SEPARATE COST (just as X-ray and Pharmacy are separate costs). UF Health Physical Therapy charges are billed as Outpatient Hospital Physical Therapy. Physical Therapy does not get billed to your student account. We are happy to assist you in any way. Please give us a call at 352-294-3065.

I have read and understand the above statement.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed patient's name**