UW Health
(University of Wisconsin Hospitals and Clinics Authority)

OUTPATIENT THERAPY CLINIC APPOINTMENT POLICY

Prescribing Physician: _____

☐ UW Health Orthotics
6220 University Ave.
Middleton, WI 53562
(608) 263-0583

☐ UW Health Research Park
621 Science Dr.
Madison, WI 53711
Spine PT (608) 265-3341
Sports PT (608) 2634765

☐ UW Health Rehab Clinic
6630 University Ave.
Middleton, WI 53562
(608) 263-8412

☐ UW Hospital and Clinics
600 Highland Ave.
Madison, WI 53792
(608) 263-8060

☐ UW Health at The American Center
4602 Eastpark Blvd.
Madison, WI 53718
(608) 440-6400

☐ Hand and Upper Extremity Rehab Clinic
1 S. Park Street
Madison, WI 53715
(608) 890-6170

☐ Orthopedic Rehab
Yahara Clinic
1050 East Broadway
Monona, WI 53716
(608) 890-6110

☐ Other:

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) 828-6600 so we can reschedule the appointment for a date and time that will work for you. 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 any non-covered services and cost-sharing outlined in your insurance plan policy. Please contact the member service department of your insurance company for accurate coverage information regarding your outpatient hospital therapy benefits.

Signature of Patient/Representative: _____ Date: _____/_____/_____Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other: _____

Reviewed by: _____ Date: _____/_____/_____Time: _____