A Step Ahead
PEDIATRIC THERAPY

ATTENDANCE CONTRACT

Patient Name: _____ **Date of Birth:** _____

In order to maximize the benefits of therapy, it is very important that all scheduled appointments be attended. "A Step Ahead Pediatric Therapy's mission is to help every child achieve his or her goal." The consistency of attending therapy sessions assures that your child will obtain maximum treatment benefit and assist in meeting your goals. A missed or late appointment disrupts therapy schedules that impact both you and our therapists. Our therapists are compensated for seen appointments only; cancellations directly affect them and our ability to provide service to you.

In signing this form, you are indicating that you understand the attendance policy and the consequences of not keeping your appointments. We anticipate that you will adhere to the following:

(Initial)

_____ I agree to call to cancel my appointments at least 24 hours in advance.

_____In the case of an emergency or illness, I understand I must contact the office at the start of the business day or as soon as possible upon noticing the illness. Family emergencies will be taken into consideration.

_____I agree to reschedule my appointment within the same week, if possible, so the cancellation is not considered an absence.

_____I understand that missing or cancelling two scheduled therapy appointments in a six month period is grounds for discharge from therapy. I understand that my physician may be notified of this failure to show for appointments and the resulting discharge from therapy.

_____I understand that I will be charged a $50.00 fee for "missed," "no show" or "no call" scheduled, appointments. This fee will be collected, from you, in full, at the next appointment. This will not billed to your insurance company. If no other appointments are scheduled then a bill will be mailed and payment is due upon receipt of the bill.

_____I understand that if I arrive fifteen minutes late, I may not receive therapy that day, depending on what the therapist had planned for that session and may be subject to the $50.00 fee.

_____I agree to notify the therapist and front desk staff at least two weeks in advance of vacations or extended leave of absence, for the duration of my scheduled treatment sessions.

_____I understand that if my regular therapist is not available, I will be given the option to see another therapist, if one is available.

_____While my child is attending therapy, I may leave during their session(s). But I must leave a contact number in case of an emergency and will return 10 minutes prior to the end of the session(s). If I am late picking up my child, I understand that I may be charged for the extra time ($32.50) due to the next appointment having to wait. This fee will be collected, from you, in full, that same day.

Following these policies will greatly facilitate quality of treatment. Thank you for your cooperation.

Parent/Guardian Signature _____ **Date** _____

Signature of A Step Ahead Representative _____ **Date** _____