ATTENDANCE CONTRACT

Patient Name_______________________________
MRN #_______________________________

In order to maximize the benefits of therapy, it is very important that all scheduled appointments be attended. 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 other patients.

"A Step Ahead Pediatric Therapy's" mission is to help every child achieve his or her goal. However time availability is a valuable commodity and if your child is discharged from our practice for attendance reasons you will be invited back but will be placed on a waiting list for an available opening.

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:

1. I understand that any appointment missed for any reason that is not rescheduled that same week is considered an absence. Two times tardy for therapy equals an absence.
2. I understand that missing three scheduled therapy appointments in a six month period is grounds for discharge from therapy. If I must cancel the appointment due to an illness or emergency, I will contact the office as soon as possible. Family emergencies will be taken into consideration.
3. I agree to call to cancel my appointments at least 24 hours in advance. If I do not call to cancel and do not attend therapy, this will be considered a "no-show."
4. I understand that two "no-shows", within a 6 month period, are grounds for discharge from therapy. **I understand that my physician or primary service coordinator will be notified of my failure to show for appointments and the resulting discharge from therapy.**
5. 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 (i.e. procedures that require a full hour to complete)
6. I agree to notify the therapist at least two weeks in advance of vacations or extended leave of absence for the duration of my scheduled treatment sessions.
7. I understand that if my regular therapist is not available, I will be given the option to see another therapist. If one is available.
8. 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 my account may be charged for the extra time ($32.50) due to the next appointment having to wait. This fee will be collected in full at the next date of service.

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

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Guardian Signature Date

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A Step Ahead Date

* Copy available upon request