Speech-Language and Swallowing Specialist, LLC.

CANCELLATION AND TARDY POLICY

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Our greatest desire is to deliver our patient’s the highest level of care available in order to maximize the benefits of therapy.

Consistent attendance demonstrates patient commitment and leads to better potential for patient progress. With your help this can

be accomplished.

Our payer sources are requesting daily progress notes as part of the review process for authorization of payment for therapy sessions. All absences are noted and require a reason for the cancellation to be noted. Excused absences include patient illness with doctor’s note or note from the parent indicating the reason for cancellation. Extenuating circumstances of absences will be considered. Numerous absences or no shows may result in therapy sessions not being covered by insurance.

Speech-Language and Swallowing Specialist, LLC. will enforce the attendance policy for clients who do not show or fail to cancel a therapy session with at least 2 hours prior notice. In order to avoid being discharged from the therapy program the patient will need to maintain an 85% attendance rate. Notifications of vacations or family obligations are requested at least two weeks prior to the expected absence, to facilitate rescheduling appointment(s).

**Cancellation = Patient has given 24 hours or more notice,**

**No Show = Patient has not given 24 hour notice or has not called to cancel**

**No Shows will be charged $25 for the visit missed.**

**Rescheduling Appointments**

Every attempt should be made to reschedule unattended therapy sessions. Reschedules sessions may occur with the patient’s

therapist or other therapists. If your therapist is ill or on vacation, the Center will provide a substitute therapist to ensure

continuation of services. We will make every effort to schedule the therapist at your regularly scheduled appointment time.

If this cannot occur, we will provide an alternate appointment time

**Late/Tardy**

Being **late** by more than 10 minutes will require you to either reschedule, wait for the next available opening, or your **treatment** time may be reduced. If your treatment is reduced, the total payment continues to be due to include copay.

Thank you for the opportunity to work with you. If you have any questions or concerns, please call and speak to the Office Manager.

**Patient’s/Guarantor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Speech-Language and Swallowing Specialist, LLC., - 16701 Melford Blvd. Bowie, MD 20715**

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