



Pediatric & Adult Therapy Services, LLC
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Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.

While **Pediatric & Adult Therapy Services, LLC** understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or “no shows”. Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted 24 hours prior to your scheduled appointment.

Review and Initial each area:

_____ A fee of \$30 may be assessed if the following occurs. This fee will be billed directly to the client and not their health insurance company, as medical insurance does not provide coverage for missed sessions.

- If cancellations are made less than the required 24 hours.
- If the client fails to show up for a scheduled appointment.

_____ If you reschedule / are late for 3 scheduled appointments within 30 days, the office will reserve the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

_____ If you fail to appear for an appointment (no show) without providing the appropriate advance notification for 3 or more appointments within 30 days, the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a client.

I, _____, understand the attendance / cancellation policy and the risks of not adhering to it.

Print Name of Client

Date

Signature of Client or Legal Representative

Relationship to Client