SPEECH SOLUTIONS

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Speech-Language Therapy Attendance/Cancellation Policy

We are pleased that you have chosen Speech Solutions to provide speech and language therapy for your family. Therapy time is very valuable as we have a list of patients waiting for therapy services. In order for them to make progress, you must bring them to therapy each week. We are committed to providing excellent therapy services and obtaining the best possible progress for you or your family member.

• A family member or caregiver must remain in the building during the entire therapy appointment, unless prior permission has been given.

• It is important that you or your family member receive all 30 minutes of each therapy session. If you are more than 15 minutes late for the therapy session, you will not be seen. There are other scheduled appointments following your time. This appointment will be classified as a **"late arrival"**.

• There may be a time when your child has to miss a therapy session for an illness. We will require a doctor's excuse for that day. If you are **NOT** going to be able to keep your therapy appointment, please call Speech Solutions at **334-699-7200** as soon as possible to CANCEL or text/call your therapist. This appointment will be classified as a **"cancellation"**.

• If you do not call and cancel your appointment, this will be classified as a **"no show"**. If you have a **"no show"** appointment or a last minute cancellation you will be responsible to pay the **$35.00** fee **BEFORE** your next scheduled appointment.

• **We will no longer provide services to you or your family member if:**

• You or your family member has two **"no show"** appointments and you don't call or text the therapist or office to let us know you or your family member won't be able to make it.

• You or your family member has **50%** or more **"canceled"** or **"no show"** therapy appointments within two consecutive months.

• You or your family member had multiple **last minute** cancellation/schedule change requests.

Please notify Speech Solutions regarding any changes in your address, phone number or insurance information prior to their therapy appointment. If we see you or your family member without prior notification of a change in insurance and services are no longer covered, **you will be held responsible of payment of that therapy session.**

***Co-Pay is due at the time of services.**

I have read this notice and agree to abide by the terms explained above.

Patient Name: _____ **Date:** _____

Parent/Guardian/Patient Signature: _____

Center Representative: _____ **Date:** _____