## BOOST Kids Attendance Policies

Updated and effective August 1, 2025

Our attendance policy is structured and implemented in order to provide the most consistent and effective treatment to your child while servicing as many families as possible with the therapy services they need. Failure to comply with the attendance policy outlined below prevents continuity of care, limits progress toward treatment goals, and does not allow for as many children as possible to be scheduled with our staff during our available office hours.

**Please read thoroughly and sign and date below** to acknowledge receipt and understanding of the updated BOOST Kids attendance policies and the potential consequences of being unable to comply with the company policies that have been set to ensure the highest quality of care possible.

1. Patients scheduled for recurring weekly or bi-weekly appointments are ***allowed 5 absences in any 6 month period***. Rescheduling of appointments will be expected within a week of the missed appointment in all non-emergency situations (vacation, alternate appointment or scheduling conflicts, transportation or child care changes, etc.) in order to maintain the required attendance rate. Appointments rescheduled the week prior to or week following the initially scheduled appointment will NOT count as an absence.

   We will make every effort to reschedule with your child's primary therapist, however some of our therapists work part-time and/or have fully booked schedules. If we are unable to reschedule with your primary therapist, your child will be rescheduled with another therapist in the office. We will ensure that the treating therapist has up to date information on your child's preferences, needs, intervention strategies, and treatment goals. _____ **Initial**

2. Cancellations: Caregivers are responsible for notifying the BOOST Kids office at (205) 767-9207 at least 48 hours prior to their scheduled appointment if they have a previously scheduled conflict or vacation. ***Cancellations due to non-emergency situations that are made less than 24 hrs before the appointment time will be considered a Late Cancel and will result in a $75 fee.***

   *If you must cancel with less than a 24 hour notice due to illness or an emergency situation, please email your therapist directly AND leave a voicemail on the office phone.
   *If a household member is sick, preventing attendance to your child's scheduled appointment, we will offer to reschedule or provide a telehealth appointment in order to limit absences . _____ **Initial**

3. No-Shows: ***If you do not notify the office of an absence, the visit will be marked as a "no-show". A $100 fee will be charged for all No Show appointments.*** Two consecutive OR three total "no-shows" will automatically result in the removal of your child from their ongoing weekly appt times. _____ **Initial**

4. Tardiness: Please call the office if you will be 10+ minutes late to your appointment. If you are more than 15 minutes late to a scheduled appt, it may need to be rescheduled. If unable to reschedule, being 15+ minutes late will be considered a No Show and will result in the $100 no-show fee. _____ **Initial**

5. Plug-In Status: If your child has 5 absences in a 6 month period OR has 2 consecutive or 3 total no-shows (including tardies), he/she will be removed from their weekly appointment time. You may have the option to move to "Plug-In Status" and call the office each Monday to schedule an appointment in the openings we have available that week. _____ **Initial**

* Clients will be eligible to return to ongoing appointments after a 90 day period, waitlist dependent
* No-show / late cancellation fees are the responsibility of the client and are not eligible for reimbursement through your insurance provider or any 3rd party payer.
* AL Medicaid does not allow for fees to be collected due to missed appointments. Medicaid clients that fall below the attendance rate OR no-show multiple appointments will have notifications sent to Medicaid and their pediatrician.

Client Name: _____ DOB: _____

Caregiver Signature: _____ Printed Name: _____ Date: _____