TOLEDO PEDIATRIC
SPEECH THERAPY

Parent Contract

Attendance and Cancellation Policy
In order to better serve you and make quicker progress toward goals, regular attendance to therapy is imperative. The most common cause of lack of progress is inconsistent attendance. Please thoroughly read your responsibilities outlined as follows:

- **Therapy sessions:**
  Please arrive on time to your session. The session will end approximately 5 minutes early to allow your therapist time to review the session with the caregiver(s), and clean up.

- **Cancellations:**
  If you are unable to attend your therapy session, please call, email, or text your therapist to notify them as early as possible.
  - *Emergency/Illness Related Cancellations:* Families will not be penalized for late cancellations due to illness or emergency situations. Please cancel your child's session if your child has vomited 2 or more times in a 24 hour period, has a rash (especially with a fever or itching), diarrhea, thick/colored drainage from his/her nose, sore throat with fever or swollen glands, a fever of over 100 degrees within the last 24 hours, he/she was kept home from school that day due to illness, or he/she does not appear to be feeling well. Just as you may have to cancel because of illness of yourself or your child, your therapist may need to cancel as well. You therapist will try to give you as much notice as possible, so it is important that she has up-to-date contact information for you.
  - *Non Emergency/Illness Related Cancellations:* "Non-emergency" cancellations require 24 hours notice and include vacations, pre-planned medical appointments, family events, parties, sports events, lack of babysitter or anything that is not designated as "emergency". If the session is not cancelled within 24 hours notice due to a non-emergency, you will be billed a $50 late-cancellation fee.

- **No Show:**
  In the event of a no-show (i.e., you do not show for a scheduled appointment or your child is not home or at school upon therapist arrival), you will be billed a $50 no-show fee. Unfortunately, we are unable to hold a therapy time for clients who demonstrate 2 or more no-show visits or whose overall attendance is below 70%.

- **Weather:**
  If the roads are unsafe for you or your therapist to travel, your session time may be changed or cancelled. Please call, text, or email your therapist if you need to cancel or make schedule changes due to weather.

Privacy Policy
Toledo Pediatric Speech Therapy, LLC's Internal Privacy Policies have been provided.

Consent to Speech Therapy Services:
I hereby consent and authorize Toledo Pediatric Speech Therapy, LLC to evaluate, diagnose, and provide speech/language treatment for: _____

Financial Agreement and Policy

Thank you for choosing Toledo Pediatric Speech Therapy, LLC! Please note that Toledo Pediatric Speech Therapy, LLC is a private pay only practice at this time and does not directly accept insurance. We will however provide documentation, when requested, for reimbursement by your insurance. Clients are responsible for confirming insurance coverage and handling all reimbursement. Please note that all insurance companies vary and speech-language therapy services may or may not be a covered benefit by your insurance.

Billing
All speech therapy services will be billed on a monthly basis. Invoices will be sent to the address you provide below:

Address: _____

Payment Terms
Payment shall be made directly to Toledo Pediatric Speech Therapy, LLC for services provided. All amounts invoiced are due within 30 days of the invoice date and are the responsibility of the client's parent/guardian/guarantor. We accept payment by personal check or Health Savings Account (HSA) check mailed to the address provided on your invoice. There is a service charge of $25.00 for any returned check. Please make checks payable to "Toledo Pediatric Speech Therapy." Speech therapists will not accept any form of payment. Payment must be sent directly to the TPST office.

Acknowledgment

I, _____, acknowledge and accept full and complete responsibility for payment of all services rendered by Toledo Pediatric Speech Therapy, LLC and/or its consultants. I understand that I am responsible for prompt payment of any cancellation or no show fees incurred as outlined in the Attendance and Cancellation Policy. I have read, understand, and hereby agree to the Financial Policy of Toledo Pediatric Speech Therapy, LLC.

I have read and agreed to all stated policies on this document

Signature: _____ Date: _____

Printed name: _____

Name of patient: _____

Relationship to patient: _____