Name: ___________________________

Speech Therapy Agreement.

Welcome to the Speech, Language and Hearing Department. We take great pride in the quality of care that we deliver. In order to achieve the best outcome for your communication or swallowing treatment, we need compliance with the below policies.

1. Scheduled therapy appointments will begin and end at the scheduled times. A patient arriving late cannot have their treatment time extended.

2. If you are going to be more than 15 minutes late for a scheduled appointment, please call and to determine whether or not your therapist will be able to see that day.

3. All cancellations must be communicated to the department secretary at 444 – 4191.

4. If you cancel or failed to show for three consecutive treatments or have less than 75% attendance, excluding on occasion for medical illness, your reserved treatment appointment will be forfeited.

5. If later you wish to return and can commit to a consistent therapy time, you will need a new physician order and then contact our office for a new appointment.

6. The department reserves the right not to reschedule future appointments for those individuals who have been discharged from therapy on two prior occasions due to these policies.

7. I understand it is my responsibility to contact my insurance to understand my co-pay responsibility, deductible and limits to my benefit plan. I am aware I will be held responsible for costs that exceed my plan.

8. All therapy co-pays need to be paid to registration in a timely manner.

Patient :Initial here________ I will pay co-pay ☐ at each visit ☐weekly ☐ monthly.

We appreciate your understanding and cooperation.

I have read, understand, and agree to abide by the aforementioned policies.

___________________________________ ________________

Patient/parent signature **Date**