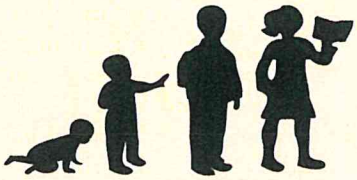
A Step Ahead
PEDIATRIC THERAPY



ATTENDANCE CONTRACT

Patient Name: _____ **Date:** _____

In order to maximize the benefits of therapy, it is very important that all scheduled appointments be attended. A Step Ahead Pediatric Therapy's mission is "to help every child achieve his or her goal." The consistency of attending therapy sessions assures that your child will obtain maximum treatment benefit and assist in meeting your goals. A missed or late appointment disrupts therapy schedules that impact both you and our therapists. (Our therapists ae compensated only when their appointments are kept.)

In signing this form, you are indicating that you understand the attendance policy and the consequences of not keeping your appointments. We anticipate that you will adhere to the following:

1. I agree to call to cancel my appointments at least 24 hours in advance.
2. In the case of an emergency or illness, I understand I must contact the office as soon as possible. Family emergencies will be taken into consideration.
3. I agree to reschedule my appointment within the same week, if possible, so the cancellation is not considered an absence.
4. I understand that missing two scheduled therapy appointments in a six-month period is grounds for discharge from therapy. I understand that my physician may be notified of this failure to show for appointments and the resulting discharge from therapy.
5. **I understand that I may be charged a $50.00 fee for "missed", or "no show" or "no call" appointments. This fee will be charged to the card on file or collected in full at the next appointment. If no other appointments are scheduled, a bill will be mailed to you. Payment is due upon receipt of the bill.**
6. I understand that if I arrive fifteen minutes late, I may not receive therapy that day, depending on what the therapist had planned for that session.
7. I agree to notify the therapist at least 2 weeks in advance of vacations or extended leave of absence for the duration of my scheduled treatment sessions.
8. I understand that if my regular therapist is not available, I will be given the option to see another therapist if one is available.
9. While my child is attending therapy, I may leave during their session(s). But I must leave a contact number in case of an emergency and will return 10 minutes prior to the end of the session(s). If I am late picking up my child, I understand that my account may be charged for the extra time ($32.50) due to the next appointment having to wait. This fee will be collected in full that same day.

Following these guidelines will greatly facilitate quality of treatment. Thank you for your cooperation.

Parent/Guardian Signature: _____ **Date:** _____

Representative of ASAPT: _____ **Date:** _____

PH: 859.426.5666 | FX: 859.426.5665 | 330 Thomas More Parkway, Ste. 102 | Crestview Hills, KY 41017