CORRECTIVE SPEECH AND LANGUAGE THERAPY, INC.
14055 Town Loop Blvd. Suite 300, Orlando, FL 32837
(407) 857-6285 ph. (407) 857-9566 fx.
www.centralfltherapy.com

Attendance Policy

Beyond Therapy is committed to providing the most comprehensive and beneficial therapy services to each patient. This is a team effort with the therapists and the families. In order for us to maintain the highest level of progress with your child, your attendance is necessary.

It is our policy to receive at least 24 hours notice for all appointment changes or cancellations. Failure to provide our office with adequate notice will result in a **$25.00** charge to your account. Your insurance company will not pay for missed visits, and you will be responsible for paying out of pocket. Please call 407-857-6285 to change or cancel your appointment or email us at Gabby@centralfltherapy.com.

3 consecutive unexcused absences will result in your child being omitted from weekly schedule. It will be necessary to contact the main office for re-scheduling on a weekly basis. **After 3 absences in any one month**, your therapist reserves the right to place your child on hold for services. Please be courteous to your therapist and make sure you give ample notice when cancelling. We understand that your child may become sick or that situations may arise in which you may have to cancel. In order to allow each child the opportunity to receive therapy from us, we must uphold our policy and cannot keep patients on the schedule who cancel or no show excessively.

Please be courteous to our other patients and be on time for your appointment. If you are more than 10 minutes late, your therapy session will be reduced or you may need to reschedule.

Your child's success is very important to us and we truly appreciate your understanding in upholding our policy. Your compliance with our Attendance Policy will allow us to provide quality treatment and maximize your child's progress and true potential.

____________________________________ __________________________
Guardian Signature Date

Unexcused Absences

Absence #1	(Therapist name(s))	Date	Guardian Signature
Absence #2	(Therapist name(s))	Date	Guardian Signature
Absence #3	(Therapist name(s))	Date	Guardian Signature