Dear Parents/Guardians

Thank you for allowing us to work with your child. In order for us to provide high quality of care for our patients we ask that you please read and sign this form with our new and existing policies.

1. The parent, guardian or responsible **adult must remain on hospital campus for the duration of the therapy session(s)**.

2. If your child is unable to attend their scheduled therapy session, please notify us at least **24 hours in advance**. You may call our office after business hours and leave a message on our voicemail.

    - **2 no shows/no calls in a 8 week period will result in loss of the permanent weekly appointment.** If you call to cancel the appointment the day of the session 2 weeks in a row that counts as 1 no show/no call.

3. **Arriving 10 minutes or more late 3 times within a 8 week period** will result in loss of the permanent weekly appointment.

I have read the above policies of the Out-Patient Therapy Department. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. By signing below I acknowledge that I understand these policies.

Parent/Guardian Signature:_______________________________________
Date:__________________

[Affix patient label]