



## Patient Service Agreement -- Clinic Copy

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**1. Consent to Treatment:**

- I authorize Family Speech & Therapy Services, LLC (FSTS) and its employees to provide speech and/or occupational therapy evaluations and treatment to me or my child.
- No guarantees have been made to me about the outcome of therapy.

**2. Arrival Policy:**

- Please arrive 5 minutes prior to your scheduled session.
- If you are late, your session will conclude at it's usual time.
- **Parents/Caregivers must be in the clinic 5 minutes prior to the end of the session.**

**3. Attendance Policy:** *(See Attendance Policy for further details)*

- If you are not able to attend a scheduled therapy session *for any reason*, and choose to not reschedule, there will be a cancellation fee of \$30.00 per session (the fee will be waived if the session is rescheduled within 30 days).
- Frequent cancelled or missed sessions may result in the loss of your reserved weekly therapy time slot.

**4. Financial Policy:** *(See Financial Policy for further details)*

- It is the patient's (or parent/guardian's) responsibility to inform FSTS of any and all changes in insurance coverage immediately. Failure to provide this information may result in patient responsibility for full amount of charges billed.
- It is your responsibility to pay any required co-payments at the time of your session.
- As a courtesy, we will file claims to your insurance company on your behalf. However, you are ultimately responsible for payment of services rendered.

**5. Discontinuation Policy:**

- When termination of therapy services is voluntary, FSTS requires two weeks notice.
- If two weeks notice is not given, cancellation fees will be applied.

6. I have been informed that my child may be seen by others during therapy sessions at FSTS. This is due to the fact that more than one child may use the occupational therapy gym and equipment at the same time. Speech therapists may also utilize the O.T. gym during speech therapy sessions.

7. FSTS is a teaching facility and at times has volunteers and speech and occupational therapy students here to observe and learn. I authorize FSTS to have students and/or volunteers observe treatment. I further authorize supervised students to work with me or my child.

8. FSTS will occasionally videotape or audiotape patients for the use of evaluation or treatment. These videos and/or audiotapes are solely used by the therapist and will remain confidential. Videos and/or audiotapes will not be released for any other purpose without prior knowledge or specific consent.

---

Patient or Parent/Guardian Signature

Date