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Kid O' Therapy Cancellation Policy

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. Advance notification of cancellations allows us to serve our patients and community to the fullest. Late cancellations negatively impacts our ability to fulfill this mission.

1. We require 48-hour notice to cancel an appointment. Patients who do not provide 48-hour notice to cancel an appointment will be considered a late cancellation. **Extenuating circumstances will be considered on a case-by-case basis.** Late cancellations are subject to the fee schedule listed below.

   First late cancellation results in a $60.00 visit charge
   Second late cancellation results in a $80.00 visit charge
   Third late cancellation results in a $120.00 visit charge and **discontinuation of services.**

   This charge **CANNOT** be billed to insurance or applied toward a deductible. This fee must be paid before the next scheduled appointment.

2. **Regarding extenuating circumstances,** we understand illness and emergencies happen. An attendance rate of 70% is required. This allows patients to make progress towards their therapeutic goals and comply with the prescribed plan of care. Attendance records will be calculated every three months and failure to maintain an attendance rate of 70% or higher may result in discontinued services.

3. If you would like to pursue services after discontinuation, you will be placed back on the wait list. Once services can resume there will be a probationary period. This requires a commitment from you to call the day prior to your appointment and confirm that your child will be attending the appointment.

To help us optimize your child's therapeutic outcomes, we request regular attendance at your occupational and physical therapy sessions as prescribed by our medical practitioners. If appointments are missed or cancelled on a regular basis, it affects your child's progress and may end up prolonging their ability to reach their therapeutic goals.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

PATIENT'S NAME: _____ Date of Birth: _____

Signature of Patient:_____ Date:_____

Signature of Responsible Party:_____ Date:_____
(if applicable)