Premier Pediatric Therapy
"Lighting the way to a brighter future"

Cancellation Policy

Premier Pediatric Therapy, P.A. recognizes your child's special needs and strives to achieve optimal therapeutic gains. The policies written below are designed to improve our ability to accommodate all patients in need of our services and to provide complete and consistent treatment for your child. Since continuity of care is important to maximizing outcomes of your child therapy, we use the following guidelines for all appointments:

In the event that unexpected circumstance make it necessary for you to reschedule or cancel your child's therapy appointment, please provide your child's therapist with at least 24 hours advanced notice. You may also leave a message on our general voicemail at (561) 670-4864.

- I understand that I will be charged a **fee of $ 35.00** for canceling my appointment without 24 hour notice, this also applies to "No Shows" (A "no-show" is defined as a missed appointment without a call or text to inform your child's therapist).
- I understand that in the event of a "no show", I will be notified via phone/text by my child's therapist. A **second** "no show" will result in the child being taken off the therapist's schedule and a charge will be assessed to the parent for that missed visit.
- I understand that my child must be in attendance for 75 percent of their scheduled therapy visits per month in order to be considered an "active" patient in our practice. Patients who drop below this amount will be given written notice of removal from the therapist's schedule and the referring physician will be notified.
- Due to the importance of your child's session, if you arrive greater than 15 minutes late for your scheduled appointment, your child may NOT be seen and this will be considered a cancellation, unless you call to notify us ahead of time.
- When a cancellation is required, our therapists will make every effort to reschedule your child at a time that is convenient for your child's therapist.
- I have read, or have had it read to me, and **understand** the information on this form. I agree with the conditions set forth.

_____ _____

Patient Signature Date

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Signature of Parent/ Guardian

Thank you for your cooperation and understanding of our cancellation policy and for helping us achieve our goal of providing the most consistent and continuous care for your child.

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