CSTC THERAPIES INC.
44081 PIPELINE PLAZA, STE 120
ASHBURN, VA 20147
(703) 723-7270
WWW.CHILDRENS-SPEECH.COM

SPEECH THERAPY
PATIENT REGISTRATION FORM

PATIENT INFORMATION DATE:

CHILD'S NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____-_____-_____ SEX: M ☐ F ☐

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SCHOOL: _____ GRADE/CLASS: _____

LANGUAGES: English (_____%) ; _____ (___%) ; _____ (___%)

DIAGNOSIS: _____ PRECAUTIONS/CONTRAINDICATION FOR THERAPY _____

ANY KNOWN ALLERGIES (e.g.,latex,food)? _____

HOW DID YOU HEAR ABOUT US ? Dr.☐ Website☐ Friend☐ Other☐

PARENT/LEGAL GUARDIAN

NAME:_____SEX: M☐ F☐ MARITAL STATUS:_____
LAST FIRST MI

RELATION TO PATIENT:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

E-MAIL ADDRESS:_____

DAY PHONE:(____)_____EVE PHONE:(____)_____CELL PHONE:(____)_____

DRIVERS LICENSE: _____STATE: _____ DATE OF BIRTH: _____- _____ - _____

EMPLOYER_____ BUSINESS ADDRESS_____

NAME:_____SEX: M☐ F☐ MARITAL STATUS:_____
LAST FIRST MI

RELATION TO PATIENT:_____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

E-MAIL ADDRESS:_____

DAY PHONE:(____)_____EVE PHONE:(____)_____CELL PHONE:(___)_____

DRIVERS LICENSE: _____ STATE: _____ DATE OF BIRTH: _____- _____ - _____

EMPLOYER_____ BUSINESS ADDRESS_____

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PATIENT'S PRIMARY PHYSICIAN

PHYSICIAN NAME_____

PRACTICE NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE: (_____)_____FAX: (_____)_____

PRIMARY INSURANCE

PRIMARY INSURANCE POLICYHOLDER: _____

RELATION TO PATIENT: _____ BIRTHDATE: _____ - _____ - _____ DRIVERS LIC. #:_____

INSURANCE COMPANY: _____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE: (_____)_____FAX: (_____)_____

SUBSCRIBER I.D. #: _____ GROUP #: _____

ACKNOWLEDGEMENTS

HIPAA: Notice of Privacy Practice

By signing this statement you are acknowledging that you have had the opportunity to receive CSTC Therapies Inc HIPAA Notice of Privacy Practices:

PATIENT NAME
(printed):_____

Signature:_____Date:_____

Parent/Legal Guardian or self

Has your child ever had any accidents, operations, or hospitalizations? (*If so, please explain and give age at which this occurred*) _____

_____

Is your child taking any medications at this time? (*If so, list medications and reason for each*) _____

_____

_____

Does your child fall or lose balance easily? _____

FEEDING HISTORY

Please check any behaviors your child **had or presently has**: (*Check all appropriate)*

___ Cough, choke, throat-clear and/or gagging during eating or drinking

___ "Wet, gurgly" sounding voice or breath during eating or drinking

___ Gagging or vomiting during or after eating or drinking

___ Drooling

___ Pain or discomfort during or after eating or drinking

___ Marked respiratory distress during feeding

___ Chronic respiratory problems

___ Rigid feeding behaviors

___ Hypersensitivity to textures or temperature

___ Refusal to eat new textures

___ Prolonged feeding times (slow eater)

___ Difficulty biting off a piece of food

___ Takes bites that are too small/too big

___ Difficulty chewing food

___ Jaw "chomps" up and down while chewing

___ Loss of food through front of mouth

___ Food or liquid coming out the nose

___ Food left in mouth after eating

___ Holds food in mouth while eating (on tongue or in cheek)

___ Tongue thrusts forward during eating

___Tongue does not move much during eating or drinking

___ Loud 'gulping' swallow during eating

___ Throws food

___ Messy eater

___ Only eats certain foods (picky eater)

___ Refuses to eat

___ Cries/screams during mealtimes

___ Takes food from others

___ Spits food

___Overeats (stuffs mouth)

___ Tries to get out of seat/leave table during meals

___ Falls asleep or fatigues during meals

___ Failure to gain weight or poor weight gain

___ Dehydration

___ Malnutrition

___Teeth grinding

___ Eats non-food items

___ Other

Describe any feeding and/or swallowing behaviors your child uses that are not listed above: _____

_____

_____

Diagnostic Procedures (*provide date and results*)

___ Modified Barium Swallow (MBS): _____

___ Video fluoroscopic swallowing study (VFSS): _____

___ fiberoptic endoscopic evaluation of swallowing (FEES): _____

___ pH/Impedance probe: _____

___ Upper GI: _____

___ Gastric emptying/Milk Scan: _____

___ Other: _____

How was your child fed as an infant? ___ breast ___ bottle ___ tube fed

How long did your child receive breast milk? _____ Formula? _____

At what age did your child eat from a spoon? _____

Describe any difficulties your child had while transitioning from breastfeeding to bottle to finger foods/spoon feeding:

_____

_____

How would you describe your child's weight? ___ ideal ___ underweight ___ overweight

Is your child on a special diet (e.g., Kosher, gluten-free, etc.)? *(If yes please describe.)* _____

_____

Does your child take any nutritional supplements? (*If so, please list the product, amount, and frequency.)* _____

_____

Has your child seen a nutritionist or dietician?_____

If so, what were the recommendations? _____

_____

Who is typically present during mealtimes? _____

Who is typically in charge of making sure your child eats?_____

How is your child seated during mealtime? (e.g., regular chair, highchair, booster seat, standing, etc.) _____

_____

Are their feet supported when they are eating? (e.g., touching the ground, supported by footrest) _____

Does your child feed themselves? ___ Yes ___ No What utensils are used? ___ spoon ___ fork ___ fingers ___ knife

How are liquids presented?

___ bottle with nipple ___ cup with wide opening (adult size) ___ cup with lid and straw

___ bottle with wide straw ___ cup with small opening (child size) ___ cup with straw (no lid)

___ plastic bottle ___ sippy cup ___other:_____

How do you know when your child is hungry? _____

How do you know when your child is full? _____

How many times a day is your child fed? _____

How long does it typically take your child to complete a meal? _____

Does your child eat more/less when they are in different environments? (e.g., school versus home) _____

Do you feel like your child likes to eat? ___ yes ___ no

Describe the sequence in which food is offered to your child (e.g., all at once, liquids always first, etc.) _____

_____

_____

What strategies or techniques have you been trying to assist your child when eating? What do you do when your child does not eat appropriately?

___ coax
___ threaten
___ offer reward
___ send to time out
___ force feeding
___ change food offered
___ limit the amount of food offered
___ present food in specific order
___ distract with play/toys
___ use TV/video
___ change meal schedule
___ model
___ spank
___ praise
___ limit food choices
___ offer small meals throughout day
___ give child free access to food
___ ignore

Other:

_____

_____

Check all of the food textures your child currently has experience with. Note if they eat it always, can eat it but does not eat it now (i.e., has outgrown or no longer a typical texture in meals), have tried it but never eat it, cannot eat it despite trying, refuse to eat it, or if the texture has not been tried yet.

Texture	Always Eats	Can Eat	Never Eats	Cannot Eat	Refuses to Eat	Not Tried
Regular liquids (e.g., water)						
Thick liquids (e.g., soup)						
Baby food						
Creamy foods (e.g., ice cream, yogurt)						
Pureed table food						
Mashed table food						
Chopped table food						
Regular table food						
Soft table food (e.g., pancakes)						
Crisp foods (e.g., crackers, toast)						
Chewy foods (e.g., meat)						
Crunchy foods (e.g., carrots, celery, pretzels)						

List any foods consistently consumed in the following categories:

Fruits:	
Meats:	
Breads/Cereals:	
Vegetables:	
Dairy Products:	
Sweets:	
Snacks:	
Beverages:	

What would you like to see your child eat? _____

_____

_____

Anything else you want us to know about your child's feeding or drinking? _____

_____

_____

FINE MOTOR DEVELOPMENT

Which hand does your child use most often? _____ right _____ left _____switches between them

Does your child have any issues with sounds? (*Please explain*) _____

Does your child have any issues with visuals (e.g., lights, colors, etc.)? (*Please explain*) _____

_____

Does your child have any issues with smells? (*Please explain*) _____

Does your child have any issues with textures they touch (e.g., squishy, rough)? (*Please explain*) _____

_____

Please describe any sensory activities that your child seeks out consistently (e.g., enjoys rocking, likes touching a specific fuzzy blanket, etc.)? _____

_____

Please check any behaviors your child **had or presently has**: (*Check all appropriate)*

___ pick up small finger foods with pincer grasp (pointer and middle finger meet the thumb)

___ pick up small finger foods with whole hand grasp

___ grasp utensils with whole hand

___ grasp utensils like the adults in the family

___ use child sized utensils

___ use adult sized utensils

___ use a knife to cut food

___ use a knife to spread toppings (e.g., butter, jam)

___ use a spoon to scoop

___ use a fork to scoop

___ use a fork to pierce

___ use a fork to cut or break food into smaller pieces

___ hold a bottle/cup with 2 hands

___ hold a bottle/cup with 1 hand

___ pour liquid from one container to another (e.g., pour milk from the carton to a cup)

___ scoop food from one container to another (e.g., serve themselves from a larger dish of food)

___ use non-dominant hand to steady/support bowl/plate when using dominant hand to pick up food

___ use dominant hand to reach across the body

___ use non-dominant hand to reach across the body

___ bring fingers/utensils loaded with food to mouth without dropping/spilling food

HEARING HISTORY

Has your child ever had an ear infection? (*If so, how many?)* _____

Date of first infection _____ Date of last infection _____

How have the infections been treated? _____

Has your child ever had tubes placed in his/her ears? (*What age & how long were they placed?)*

_____

Has your child ever had a hearing screening or evaluation? *(If so, please indicate when, where and results)* _____

_____

SPEECH LANGUAGE DEVELOPMENT

When did your child say their first word? _____ Combine 2-3 words? _____

Language(s) spoken at home: _____

Describe your child's speech/language: _____

_____

_____

Has your child's language continued to develop in a normal progression or has it stopped/regressed? _____

_____

Has your child ever had a speech/language screening, evaluation, or treatment? (*If so, what were the results of the evaluation and how long did your child have therapy and where?*) _____

_____

_____

Was your child discharged from treatment? (*If so when*) _____

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CSTC Office Policies

1. **PAYMENT IS DUE AT THE TIME OF SERVICE** unless other arrangements have been made with our office.
2. Third party reimbursement should be paid directly to parents unless the insurance carrier requires that payment be made to **CSTC** directly. You are obligated to pay us for all services provided on your behalf, regardless of whether or not other services are covered by your policy with your insurance carrier. You are responsible for providing the required information necessary for obtaining insurance coverage and authorization. We will be happy to assist you.
3. Regular attendance is essential for your child's growth in therapy. Your child's appointment time has been exclusively reserved for you and your child. However, should you need to cancel a session, please try and reschedule your cancelled session. If more than 2 cancellations occur and are not made up per 3-month period, a $37.50 missed therapy fee will be applied.
4. **A therapy session missed with no prior notice or phone call (No show) will be charged $75 for missed therapy session**. Exception to this charge policy will be considered if the client makes up the session at a time available in the therapist's schedule.
5. All cancellations will be billed directly to client. **No cancellations will go through your insurance company.**
6. **If 3 or more no shows occur in a 3-month period, CSTC Therapies reserves the right to discontinue treatment.**
7. Please note that **we do NOT follow the school calendar** regarding holidays and inclement weather. Please confirm appointments with your therapist if you have any questions regarding your therapy schedule.
8. Please give your therapist at least 2-weeks notice if you need a written report/letter, etc. for an IEP meeting or other professional meeting.
9. If you leave and do not pick your child up on time, there will be a $30 charge for each 5-minute increment that you are late. There is no one here to watch your child if you are late to pick them up. Our therapists have to push back their sessions and the following sessions are late for the rest of the day. It also doesn't allow for your therapist to effectively communicate with you following the session. **This charge will not be billed to your insurance company.**

By signing below, I acknowledge receipt CSTC Policy Statement and agree to the terms stipulated above.

_____ _____

Parent's Signature Child's Name

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Release of Information

I give permission for Children's Speech Therapy Center to release information regarding

_____ to _____
(child's name) (name of doctor, school, therapist, etc.)

_____
(doctor's, school's, therapist's address and phone number)

_____ _____
(parent/guardian's signature) (date)

Videotaping and Photography

Use of videotaping and/or photography is often used in order to aid in the assessment, evaluation, and/or treatment of your child. These photos and videos are used solely for the purposes of visual aids during therapy, documentation and assessment of progress over time. CSTC Therapies will protect all videos and photographs and will follow all confidentiality for our clients.

_____(Please initial) I give permission for my child to be videotaped and/or photographed for the aforementioned purposes and will not be shared with any person outside this practice.

_____ _____

Parent Signature Date

Email

_____(Please initial) I give permission for CSTC Therapies to contact me via email regarding my child's speech therapy session.

_____(Please initial) I give permission for CSTC Therapies to send documentation such as evaluations, progress reports, and/or treatment plans via email.

_____ _____

Signature Date

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120 ASHBURN, VA 20147
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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Will Follow This Notice

This joint notice applies to our staff, business associates and therapists while they are treating you in our facility. It describes how we will use and share your information, how we are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your health or condition and related health care services. We are required to abide by the terms of the notice currently in effect. If you have questions about any part of this notice or if you want more information about our privacy practices, please contact our HIPAA Compliance Officer at (703) 723-7270.

I. How we may use or share your health information. We are committed to protecting the privacy of your health information. The law permits us to use or share your health information for the following purposes:

1. *Treatment.* We may use or share your PHI with physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

2. *Payment.* We may use or share your PHI to obtain payment for your health care services. For example, obtaining approval for payment of services from your health plan may require that your PHI be shared with your health plan. We may also provide your PHI to our business associates, such as billing companies.

3. *Health Care Operations.* We may use or share your PHI in order to operate our facilities. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. *Notification and Communication with Family.* We may release your PHI to a relative, close friend, or any other person you identify, information that directly relates to that person's involvement in your health care unless you object. If you are unable to agree or object to the release, we may release information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or release PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care to tell them your location or general condition. Finally, we may use or share your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and releases to family or other individuals involved in your health care.

5. *Required by law, court, or law enforcement.* We may release PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with crime; or when ordered by a court.

6. *Public Health.* As required by law, we may release PHI to public health authorities for purposes related to preventing or controlling disease, injury or disability; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

7. *Research.* We may release your health information to researchers conducting research that has been approved by an Institutional Review Board.

8. *Specific Government Functions.* We may share your health information for military or national security purposes

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9. *Appointment Reminders & Health Related Benefits.* We may use your PHI to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

10. Diagnostic and therapeutic information regarding psychiatric, drug/alcohol abuse, or sexually transmitted diseases (including HIV status) will not be disclosed without your specific permission, unless required by law.

II. Your Health Information Rights

1. *You have the right to request a limit on certain uses and releases of your health information.* We will consider your request, but are not required to accept it. These requests must be in writing and submitted to our HIPAA Compliance Officer.

2. *You have the right to choose how you receive your health information.* You have the right to ask that we send information to you at an alternative address or by other means (for example, telephone instead of mail, post office box instead of home address). We must agree to your request so long as we can easily provide it in the format you requested. These requests must be in writing.

3. *You have the right to see and get copies of your health information, in most cases.* These requests must be in writing.

4. *You have a right to request that we correct or update information that is incorrect or incomplete.* We are not required to change your health information. If we deny your request, we will provide you with information about our denial and how you can disagree with the denial. These requests must be in writing.

5. *You have a right to receive a list of disclosures we have* made except that we do not have to account for the disclosures described under treatment, payment, health care operations; information provided to you; information released based on your written authorization; directory listings; certain government functions; disclosures of a limited data set (which may only include date information and limited address information); and to correctional institutions or law enforcement in custodial situations. These requests must be in writing and must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.

6. *You have a right to get a paper copy of this Notice of Privacy Practices.* You may request a copy of this notice at any time.

III. Changes to this Notice of Privacy Practices
We reserve the right to change this Notice of Privacy Practices at any time in the future. We reserve the right to make the changed notice effective for health information we already have about you as well as any we receive in the future. We will post a current copy of the Notice. Upon request, you may obtain a copy of the current notice by contacting our HIPPA Compliance Officer at (703) 723-7270.

IV. When We May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

V. Complaints
If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Compliance Officer or with the Secretary of the Department of Health & Human Services. To file a complaint with our HIPAA Compliance Officer, call (703) 723-7270.

You will not be penalized for filing a complaint.

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INSURANCE CERTIFICATION AND RELEASE AUTHORIZATION

This is to certify that I, _____ authorize CSTC Therapies Inc. to apply for benefits for services rendered to me or my child by thespeech pathologists, occupational therapists, and /or physical therapists at CSTC Therapies Inc. If payment is not made to CSTC for any reason, I understand and agree that I am responsible for payment in full for any/all services that I have received from CSTC Therapies Inc.

I further certify that the information I have provided concerning my insurance coverage is correct. I also realize that confirming coverage of insurance benefits is a courtesy done on my behalf by CSTC Therapies Inc. I understand and agree that I am ultimately responsible for checking with my insurance company/carrier as a follow-up, and that failure to do so may result in a lesser payment or no payment at all.

I understand and agree that any and all referral documentation and or information, if required by my insurance carrier, is MY RESPONSIBILITY to obtain and provide to CSTC Therapies Inc by no later than the date of my appointment.

I further authorize CSTC Therapies Inc to release any information, including medical information for this or any related claims to any insurance company or reimbursing agency in order to determine benefits to which I may be entitled.

I have read, understand, and agree to the above:

_____
Signature of Responsible Party

If the patient is under the age of 18, please complete the following: The undersigned is a parent/guardian of the patient and executes this form on their behalf:

_____
Signature of parent/guardian

_____
Please print name and relationship to patient

Date form completed: _____

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PATIENT FINANCIAL AGREEMENT

We are pleased you have chosen CSTC Therapies Inc. for your speech therapy care. We are dedicated to providing our patients with the best possible care and service, while keeping the costs affordable. We do not render service in order to collect money, but we must collect in order to render service. We ask your help by understanding and cooperating with our financial policy.

We believe that our Patient Financial Agreement is important and it is our responsibility to inform you of charges and our payment guidelines prior to treatment. Determining costs for insured patients is more difficult and less accurate. Your insurance is a contract between your employer and an insurance company. Benefits received are based on the terms of the contract negotiated between your employer and the insurance company, and not CSTC Therapies Inc. The goal of insurance policies is to provide basic care and many needed services may not be covered. Our office will do everything possible to help you understand and make the most of your insurance benefits. As a courtesy, our office will complete and submit your insurance forms to achieve the maximum reimbursement to which you are entitled. Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your insurance policy so that you are fully aware of coverage and any limitations of the benefits provided. We will gladly discuss our payment options with you before beginning your treatment.

Insurance:
We participate with certain insurance plans. It is your responsibility to provide us with your correct and current insurance information at the time of your visit and to make sure that we are providers with your specific plan. If you fail to present the correct and current insurance information at the time of your visit, then you agree to be responsible for 100% of our usual and customary charges for your visit.

If we participate with your plan, we will provide the service if filing a claim to your insurance company for office charges, unless we have received prior notification of non-covered services. Those services, along with all co-pays and deductibles are the patient's responsibility and must be paid at the time of your visit. Any fees not billable to insurance will be disclosed in advance, and you will be required to sign a waiver acknowledging our policy before services will be rendered. In addition, you will be given the necessary paperwork to file to your insurance company.

We will file the initial claim to your insurance company. Our office policy is to allow for one subsequent filing. If, after the second filing the claim remains unpaid, then the balance will be transferred to your responsibility and payment will be expected upon receipt of a statement. We will work with you to ensure that our services have been billed correctly. The ultimate responsibility for the timely payment for services rendered is yours. If you are owed a refund, the refund will only be issued when your account balance is zero.

If we do not participate with your insurance, payment in full will be due at the time of your visit.

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Payment for services performed:
Our office accepts cash, personal checks, Visa, MasterCard, and Discover. All copays need to be paid at the time of service. There is a $40.00 charge for returned checks. Any patients requiring coespondence via certified mail will be charged a $20.00 fee. All outstanding balances are due within thirty (30) days, unless prior arrangements are made with the billing office. All copays must be paid by the end of the month. Any balance on copays left at the end of the month will be charged a finance charge of 10% of your remaining balance. All balances over 90 days may be sent to a collection agency. You will be financially responsible for all collection and legal fees incurred by CSTC Therapies Inc in the collection of your delinquent balance.

The patient and/or responsible party has received, read and understand the financial agreement. The patient and /or responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with whom this office has a contracted agreement, the patient and /or responsible party agree to pay all applicable co-payments, and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to the patient, which is not considered to be covered by insurance.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY SET FORTH BY CSTC THERAPIES INC AND AGREE TO THE TERMS. I ALSO UNDERSTAND THAT THE TERMS OF THIS POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____

Parent's Signature Child's Name

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Cancellation Policy

Regular attendance is essential for your child's growth in therapy. Please remember that once a therapy time has been set, that time is reserved for you. However, we understand that there are times when you cannot make a therapy session. Our cancellation policy is below. Please read it over and sign below. If you have any questions, please feel free to ask your therapist or email us at info@childrens-speech.com

- No more than 2 missed therapy sessions may occur within a quarterly period. Our quarters are defined as follows: Q1 = January, February, March; Q2 = April, May, June; Q3 = July, August, September; Q4 = October, November, December. If more than 2 cancellations occur, it is your responsibility to reschedule a make-up session during a time that your therapist has availability in order to avoid the missed appointment fee of $37.50 per missed therapy session.
  - Rescheduled therapy sessions must occur within the same quarter as the canceled session. Any sessions not made up by the end of the quarter will be billed at the end of the quarter.
- A therapy session missed with no prior notice or phone call (No show) will be charged $75 for missed therapy session.
  - Exception to this charge policy may be considered if the client makes up the session at a time available in the therapist's schedule.

- All cancellation fees will be billed directly to client. **No cancellation fees will go through your insurance company.**

- **Our answering machine is on 24 hours a day, 7 days a week**. You can call at any time during the day or night to notify CSTC Therapies that you need to cancel your appointment. You may also email your therapist to cancel at anytime.

- **If 3 or more no-shows occur within a quarter, your spot will be removed from the schedule. Please call us back to reschedule a permanent therapy time.**

- Inclement weather – CSTC Therapies **does not** follow the school schedule or closing schedule for inclement weather. CSTC Therapies will inform you of an office closing or therapy cancellation via email and/or phone.

By signing below, I acknowledge receipt of the cancellation policy and agree to the terms above.

_____ _____

Parent's Signature/Child's Name Date