UNIFIED THERAPY SERVICES PEDIATRIC PATIENT ATTENDANCE/TARDINESS POLICY

I understand that it is my responsibility to have ___________________________attend all scheduled therapy appointments or to *call and cancel at least 2 hours in advance.* I further understand that messages may be left on the answering machine after hours and the staff of Unified Therapy Services (UTS) will receive these messages the following day.

I understand that if he/she does not attend the schedule appointment and if the staff of UTS then has to call me, this will be considered a **No Call/No Show (NC/NS)** visit.

I understand that the therapist (s) will **verbally discuss attendance policy** for the above named patient if he/she has 2 consecutive cancellations or 1 NC/NS.

I understand that the therapists (s) **will send a written notification for** the above named patient if he/she has 2 consecutive NC/NS, 3 consecutive cancellations, or if attendance is less than 60% for the given quarter.

I understand that the above named patient **may be discharged** from all therapy services if he/she has 3 consecutive NC/NS visits, 4 consecutive cancellations, or if frequency of attendance has not improved to greater than 60% by the end of the following quarter.

I understand there may be extended excused absences related to hospitalizations, surgery, injuries, illness, and intense therapy programs. or extended vacations.

I understand that any child age 12 and under must be accompanied to and from therapy until contact is made with a therapist.

I understand that if I am not accompanying the above named patient to therapy it is my responsibility to have her/him dropped off and picked up on time for all therapy appointments. I understand that if he/she is **tardy in excess of five times**, the therapist will verbally discuss the importance of timeliness.

I understand that if tardiness continues after the verbal discussion, the therapist and front desk personnel will make a change in the schedule (if available) in order to address the issue of tardiness.

I understand that if tardiness continues after a therapy time change, that the above named patient **may be discharged from therapy.**

I understand any exception will be at the discretion of Unified Therapy Services.

By signing below I indicate that I have read the above stated policy.

____ ___________________

Patient/Caregiver Signature Date

____ ___________________

Staff Signature Date