



### **Attendance and Cancellation Policy**

In order to maximize the benefits of therapy as prescribed by your child's physician and therapist's directives, it is important that all scheduled appointments be attended. The consistency of attending therapy session assures that your child will obtain maximum treatment benefits in meeting their goals. A missed or late appointment disrupts therapy schedules that impact your child, other clients, and your therapist.

Jumping Jelly Beans Pediatric Therapy's mission is to help every child achieve their goals. However, time availability of our therapists is a commodity and failure to comply with the attendance and cancellation policy will result in us not being able to hold your child's appointment spot and ultimately dismissal from therapy.

In signing this form, you are indicating that you understand the attendance policy and the consequences of not keeping your appointments. We anticipate you will adhere to the following:

1. I understand that not maintaining 75% attendance per month is grounds for discharge from therapy. ( If you are scheduled for 8 sessions per month you must attend 6/8 visits. If you are scheduled for 4 sessions per month you must attend  $\frac{3}{4}$  sessions.)
2. I understand if my regular appointment time is difficult to maintain, I will inform my therapist and discuss the possibility of a different day and time.
3. Except for emergency situations, all appointments must be cancelled 24 hours in advance by calling the office or notifying the therapist of the cancellation.
4. I agree that in the event of an emergency situation, appointments must be cancelled as early as possible before the appointment time.
5. I understand that if JJB is closed due to inclement weather, we will contact you. If our offices are open and you decide to cancel due to inclement weather, appointment must be cancelled as early as possible before appointment time.
6. I understand if I arrive 15 minutes late, I may not receive therapy that day or receive the full amount of minutes depending on the therapist's availability and at his/her discretion.
7. I understand while my child is attending therapy, I may leave during their sessions. I agree I must leave a contact number in case of an emergency and return 10 minutes prior to the end of the session.
8. I understand that if I am discharged for not adhering to the any of the above goals, JJB will send a letter of discharge to your child's PCP explaining reasons for discharge.

**MY SIGNATURE BELOW INDICATES THAT I HAVE READ THE ABOVE POLICY AND UNDERSTAND THE TERMS AND CONDITIONS.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name