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**ATTENDANCE POLICY**

Your child’s success in speech therapy can be greatly enhanced with regular attendance, communicating with your therapist and practicing the homework provided by your therapist.

Foundation Communication implements this attendance policy to monitor and ensure that patients regularly attend their scheduled appointments for an overall successful speech therapy program. The policy states that patients may be removed from the schedule for any of the following reasons:

**- Three consecutive missed or canceled appointments**

**- Two no shows (i.e. missed appointments without a telephone call to cancel)**

**- Inconsistent attendance (including arriving late for appointments)**

All of the above may adversely affect your progress and success at speech therapy. In the event of any of the above reasons, therapy patients may be removed from the schedule and placed on a wait list. If you are removed from the schedule because of attendance problems, re-admission to therapy will require approval of the treating therapist.

Punctuality for appointments allows adequate therapist/patient interaction and also time to report outcomes to parents. If you are 10 minutes or more late, you may not be able to be seen at that time and could have to wait until your next scheduled appointment.

A minimum of twenty-four (24) hours notice is requested for cancellations and rescheduling requests. But, we do understand that illnesses and emergencies happen suddenly and may require a last minute notification. Attendance when sick is NOT encouraged! In the best interests of your child, please try to re-schedule their appointment if a cancellation is required.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the above attendance policy and understand that my cooperation and participation contributes to the success of my child’s therapy program.

Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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