



### Payment & Cancellation Agreement

I, \_\_\_\_\_ (parent/guardian), acknowledge and accept full and complete responsibility for prompt payment of all services rendered to \_\_\_\_\_ (child/client) by Spectrum Pediatrics, LLC.

I agree that payment in full is due at the time of treatment. Additionally, I understand that I will be assessed a \$30.00 fee for any payments returned to Spectrum Pediatrics, LLC.

I have been informed by Spectrum Pediatrics, LLC of the following changes regarding cancellations:

- No fee will be charged for cancellations prior to 7AM on the day of therapy
- A \$30 fee will be charged for cancellations made after 7AM and those made up to one hour before scheduled therapy time on day of scheduled appointment.
- A full session fee will be charged for visits:
  - I. canceled less than 1 hour before the scheduled therapy time;
  - II. if the therapist shows up and no one is available for therapy; or
  - III. if your child arrives sick
    - a. has a fever,
    - b. is too sick to participate in therapy or
    - c. the therapist deems the session cannot continue because the child is too sick

If you call to cancel your child's scheduled appointment and the office is closed, please contact your therapist directly and leave the following information on the office voicemail: Your child/children(s) full name, appointment date(s) and appointment time(s). If you are canceling with less than 24-hours notice, please contact your therapist directly, in addition to contacting the office.

I acknowledge that I have received written explanation of the fee structure and the cancellation policy and I agree to both.

The fees that I am charged by Spectrum Pediatrics, LLC are in no way related to health insurance or educational reimbursement. I understand that I am personally responsible for direct payment to Spectrum Pediatrics, LLC, regardless of any reimbursement issues that I choose to investigate.

\_\_\_\_\_  
SIGNATURE (parent or legal guardian)

\_\_\_\_\_  
DATE