PEDIATRIC ASSOCIATES
OF MT. CARMEL, INC.

4371 Ferguson Drive
Cincinnati, Ohio 45245
(513)- 752-3650

Therapy Attendance Agreement

Our goal at PAMC is to provide you with the best services and we would like to inform you of our therapy attendance policy to ensure that you are getting the treatment that you need. We also want to ensure, other patients are not missing out on possible therapy times that they could have received.

Please read through and initial on the line that you have read and understand each statement:

____ I UNDERSTAND that if I arrive 15 minutes late to a 45 minute session, or 10 minutes late to a 30 minute session without prior notification, I may not receive therapy that day. Sessions that begin late will still end at your scheduled appointment time.

____ I AGREE to call to cancel my appointments at least 24 hours in advance. If I do not call to cancel and do not attend therapy, this will be considered a "no-show."

_____ IF I AM IN QUARANTINE, or otherwise are unable to physically attend but are able to engage in talk therapy, I will call the office to change the appointment to a telehealth appointment.

_____ I UNDERSTAND that if I have multiple cancellations, instances of tardiness, or missed appointments, it is grounds for discharge from therapy. If I must cancel an appointment due to an illness or emergency, I will contact the office as soon as possible. Family emergencies will be taken into consideration.

_____IF I do not attend at least one therapy session within a 3 month period, this is grounds for discharge from therapy, as no therapeutic benefit can be gained from inconsistent therapy sessions.

_____ IF I miss three (3) consecutive therapy sessions and do not call, I will be discharged from therapy at the discretion of the therapist.

_____ IF I cancel my intake appointment within 24 hours of the appointment time, I will be given one more chance. Failure to show up the second time to the intake appointment will result in discharge from therapy.

Once discharged from therapy (whether successfully or unsuccessfully), you may reenter therapy services if needed after one year or earlier based on therapist's discretion.

Please sign that you understand and agree to the above policy:

_____ _____

Name of Patient Date of Birth

_____ _____

Signature of patient or responsible party Date

_____

Relationship to patient