Connections
Therapy Centers

connectionstherapies.com
A Provider for Mountain View Hospital

Attendance Policy

Your therapist:________________________ Therapist cell:________________________

____________________________________ ______________________________
Day(s) Time(s)

Attendance Policy:

I understand that I/my child cannot benefit from therapy services without good attendance. I understand that there is a waiting list for therapy services, especially afternoon hours. I understand that I am/my child is expected to attend therapy at the scheduled appointment times weekly. If attendance is below 85%, or three appointments are missed without calling, I/he/she <u>may</u> be discharged and placed at the bottom of the waiting list. If I/my child need(s) to miss an appointment, I will call ahead and give as much notice as possible. I also understand that therapists have scheduled back-to-back appointments and, as a courtesy to my therapist and other clients, I will make every effort to be on time for drop off and/or pick up times.

Your therapist will give you as much notice as possible should she/he need to cancel an appointment. Please make sure your therapist has current contact information.

____ ____________
Signature (Patient or parent/guardian) Date

____________________________________ ________________________________
Email (Patient or parent/guardian) Cell Phone (Patient or parent/guardian)