PRACTICE POLICIES AND PROCEDURES AGREEMENT

PAYMENT PROCEDURE: Private pay clients are required to pay for services upon receiving therapy. (initials) _____

24 HOUR CANCELLATION POLICY: If there is a need for cancellation and/or change of appointment, the Client(s) is to call Columbia Speaks' clinicians to inform him/her of your need at least 24 hours prior to the appointment. If a cancellation occurs more than 3 times without 24 hour notice, the clinician has the right to discontinue therapy. (initials) _____

PHONE POLICY: Columbia Speaks will provide clients with current, working phone numbers. The clinicians will be sure to return your phone call within 24 hours. (initials) _____

TERMINATION: The Client(s) may terminate speech pathology at anytime. Cancellation must be in writing, by fax or E-mail, with at least a two week notice. (initials) _____

NATURE OF RELATIONSHIP: Columbia Speaks will concentrate efforts on improving speech and language skills, enhancing behavior and play skills as well as establishing habits that produce success at home and at school. Sessions may also include coaching parents in ways to modifying child behavior, increasing compliance and developing self-esteem

CONFIDENTIALITY: Columbia Speaks recognizes that the Client(s) will likely discuss confidential issues during the sessions, any of which might include: family issues or concerns, marital difficulties, problems with children, future plans, financial information, job information, goals, personal information, and other private information. Columbia Speaks will not at anytime, either directly or indirectly, voluntarily disclose, or communicate this information to a third party. Columbia Speaks will not voluntarily divulge that Columbia Speaks and the Client(s) are in a therapeutic relationship without the expressed written permission of the Client(s). This confidentiality agreement does not apply to illegal activities, child abuse, or plans to conduct harmful or illegal activities.
(Client initials) _____ (Clinician initials) _____
Your initials and signature upon this document indicate your acceptance of all conditions listed therein.

The Client(s):

(Print Name) _____ Date _____

(Signature) _____

(Print Name) _____ Date _____

(Signature) _____

Clinician:

(Print Name) _____ Date _____

(Signature) _____