PSLS
Pediatric Speech & Language Services, Inc.

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Child's Name: _____ Date of Birth: _____

Cancellation Policy

I, _____, understand that I am responsible for canceling therapy sessions at least 24 hours before the session begins. If proper notification is not given to the therapist on two occasions, I understand that services may be terminated.

_____ _____

Parent/Guardian Signature Date

As an employee of PSLS, and as a result of previous violations of this policy, I reviewed this policy and possible consequences with the parent.

_____ _____

Employee Signature Date