



**Mansfield Pediatric Therapy, LLC**  
**1 Marion Avenue, Suite 107 Mansfield, Ohio 44903**  
**[mansfieldpediatrictherapy@gmail.com](mailto:mansfieldpediatrictherapy@gmail.com)**  
**419-989-1416**

### **Attendance / Cancellation Policy**

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.

While Mansfield Pediatric Therapy, LLC understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted 4 hours prior to your scheduled appointment.

☐ A fee of \$50 may be assessed if the following occurs (this fee will be billed directly to the client and not their health insurance company, as medical insurance does not provide coverage for missed sessions):

- If cancellations are made less than the required 4 hours.
- If the client fails to show up for a scheduled appointment.

☐ If you are late for 2 scheduled appointments with Mansfield Pediatric Therapy, LLC, the office will reserve the right to discharge the patient. Additionally, if you arrive more than 10 minutes late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

☐ If you fail to appear for an appointment (no show) without providing the appropriate advance notification for 2 or more appointments, the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a patient.

☐ If you fail to maintain an attendance rate of 80% (through cancellations, missed appointments, or late appointments), the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a patient.

☐ I, \_\_\_\_\_, understand the attendance / cancellation policy and the risks of not adhering to it.

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or  
Legal Representative

\_\_\_\_\_  
Relationship to Patient