

570 West Crossville Road● Unit # 104 ● Roswell, GA 30075

Phone: 404-547-0825 Fax: 770-783-6618 [www.brighthorizonstherapy.com](http://www.brighthorizonstherapy.com)

**Attendance Policy**

Your child will benefit greatly by coming to their therapy sessions on a consistent basis; therefore it is important to notify Bright Horizons Pediatric Therapy, LLC if your child will not be able to attend their scheduled therapy session. You are required to give a **24 hour notice** of your cancellation. If you fail to do so a **$35 fee** will be charged for the missed session. **A $35 fee will also be charged if you miss two consecutive scheduled therapy sessions in a row (even with a 24 hour notice).**

Please do not let your child attend a therapy session if they are exhibiting any of the following symptoms:

1. Vomiting
2. Diarrhea
3. Fever over 100 degrees
4. Pink eye
5. Strep throat
6. Flu

If your child has had any of the above stated symptoms, please make sure they are symptom free for at least 24 hours before attending their scheduled therapy session.

I have read and agree to follow Bright Horizons Pediatric Therapy, LLC attendance policy and understand the conditions if I fail to abide by it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Child’s name