**Allegretto Therapy Services, LLC**

**694 Wharton Blvd.**

**Exton, Pa. 19341**

**(610)-715-2702**

**Policies and Guidelines**

**Missed Appointments**

Out of respect for our therapists and other clients, we ask that you provide us with 24-hour notice for cancellations, with the exception of emergencies. If you fail to provide adequate notice of your cancellation, you will be charged a missed appointment fee equal to the full rate charged for your scheduled session. We greatly appreciate your cooperation in helping us to keep our appointments running on time.

**Payment for Services**

Copays and out of pocket payments are expected when services are rendered. If payment is not made by the second session a %25 penalty will be added and you will be denied service until payment is received.

It is your responsibility to find out from your insurance company if a referral, precertification or authorization is needed before treatment. If you neglect to obtain this information and your insurance does not cover any portion of therapy that would otherwise be covered if a referral, precertification or authorization was obtained, you are responsible for paying the full amount owed. You are also responsible for payment of deductibles and co-pays incurred during the course of treatment that are not covered by insurance as well as keeping track of any changes and ongoing requirements to your insurance policy.

Please note a 10 minute consultation is included within our sessions. If you wish to have a longer consultation with a therapist you will be charged the full rate for any consultations provided by a therapist. In addition you will be charged the full rate for meetings attended by a therapist, and observations made by a therapist. These services are **not** covered by insurance and are your responsibility.

If insurance is billed and does not cover expenses, payment is expected within 2 weeks once services begin or services will be discontinued until payment is made.

**Health and Wellness**

If your child is sick, we ask that you do **not** bring your child for his/her appointment. We strive to provide a clean and healthy environment for all of our families. If you do bring your child when he or she is not feeling well, we have the right to refuse therapy for that session.

I understand that I must provide 24-hour notice if I need to cancel my appointment and that I will be charged the full fee for my scheduled session if I do not give sufficient notice.

I also understand the above insurance and related payment policies and agree to their terms.

I further understand the above health and wellness policy and agree to its terms.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_