Chris Byers, MA, CCC-SLP
Speech-Language Pathologist
License #SP 10464
Phone: (818) 419-1123

CONTRACT FOR SERVICES

(Please print clearly)

Patient Name: _____

DOB: _____

Parent/Guardian Name(s): _____

Address:
_____

Phone: Home _____
Cell _____

Email: _____

Referred By: _____

Fees will be agreed upon by patient and therapist at the commencement of treatment.

Payment is due at the end of each session. Cash, checks, or major credit cards are accepted. A small convenience fee will be charged for credit card payments.

The client is responsible for giving **24 hours** notice for cancellation of an appointment except for illness or emergencies. Otherwise, full fee for that appointment will be charged. Multiple cancellations may result in termination of services.

Sessions are 25 or 50 minutes in length beginning at the scheduled appointment time.

Permission to allow video and/or still photography for therapeutic purposes:

☐ I agree to allow video and/or still photography for therapeutic purposes only.

☐ I do not agree to video and/or still photography.

I welcome any discussion regarding the above.

_____ _____
Signature Date

_____
Print name

_____
Relationship to patient