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## Permission to participate/payment terms "M.A.G.I.C."

I \_\_\_\_\_ give permission for my child \_\_\_\_\_  
(Name of Legal Representative or Client) (Name of Client Being Treated)

to attend Capitol City Speech Therapy's "M.A.G.I.C" preschool program. I understand that my child will be working with other children and their family members, who will be observing and assisting with the class.

I agree to pay for each class a month in advance. Payment is due on the first of each month. Payments can be made by cash, check or charge. If payment is not received by the 10<sup>th</sup> of the month a 5% late fee will be added. The main office will be responsible for accepting payments. I also understand that if sessions are missed due to client cancelations, there will be no refunds. I also understand that my insurance will NOT be billed for the Preschool Class.

\_\_\_\_\_ Yearly Registration fee \$100

\_\_\_\_\_ Monthly Rate \$150 (Regular registration)

\_\_\_\_\_ I want my insurance billed for therapy services and agree to pay the co-pay

\_\_\_\_\_ I do not want my insurance billed for therapy services and agree to pay for each session privately

\_\_\_\_\_ I want to pay for 16 weeks (first 4 months in advance) to receive a 5% discount

My rate \_\_\_\_\_ Early Bird Discount \_\_\_\_\_ Total: \_\_\_\_\_ monthly/semi-annual

Registration: \_\_\_\_\_

By signing this form, it indicates that I have **read** and **fully understand** the terms listed above.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Signature of Client / Legal Representative      Relationship      Date**