



141 N Main Street
Fuquay-Varina, NC 27526

3700 National Drive #219
Raleigh NC 27612.

Office: 919-577-6807 Fax: 919-577-6853
Mobile: 919-434-4596
www.capitolcityspeechtherapy.com

Permission to participate/payment terms

TRACK-OUT

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

to attend Capitol City Speech Therapy's "Track Out" 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. Payments can be made by cash, check or charge. 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.

_____ Registration fee \$10.00

_____ Monthly Rate \$75 (Regular registration)

Total: _____

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

_____/_____/_____
Signature of Client / Legal Representative Relationship Date