elevate
OT • PT • ST
303 SW 18th Street Suite 1 & 3 Bentonville, AR 72712
P: 479.360.6896 F: 479.360.6814

OFFICE POLICIES

Thank you for choosing Elevate Pediatric Therapy for your child's care. We are committed to providing high-quality, family-centered services. The policies below help ensure consistent, effective therapy and clear communication.

ATTENDANCE

Regular attendance is essential for your child's progress. Consistency helps children build rapport with their therapist, maintain routines, and make steady gains.

- Your child must attend therapy at least 80% of the time weekly to maintain their schedule.
- Please notify your child's therapist if you will be arriving late for the therapy session.
- If therapy attendance falls below 80% for four consecutive weeks, therapy sessions will be reduced or your child will be removed from their therapist's schedule.
- If your child is unable to attend their therapy session(s), please notify us as early as possible.
- Not calling to cancel your child's therapy session will result in a "no call, no show", which may result in a cancellation fee.

SICK

To protect all children and staff, please keep your child home if they have:

- Fever (100 degrees or higher) within the past 24 hours
- Vomiting or diarrhea within the past 24 hours
- Contagious illness
- Symptoms that would prevent participation in a school setting

WEATHER

- For inclement weather, we will communicate with our families when we close the clinic via telephone, social media, and/or website. Please contact us directly with questions or concerns at any time. The clinic will most likely be closed when Bentonville or Rogers public schools are closed due to inclement weather.

PAYMENT

- Families are responsible for notifying us of insurance changes.
- Copays, deductibles, or private pay amounts are due at the time of service.
- Any remaining balance not covered by insurance is the caregiver's responsibility.
- Billing statements are sent out monthly.

ACKNOWLEDGEMENT

I have read and understand the Office Policies for Elevate Pediatric Therapy. I agree to follow these guidelines to support my child's progress and continuity of care.

Child's Name: _____

Parent/Guardian Name: _____

Signature: _____ Date: _____