PAYMENT AGREEMENT

I, the undersigned____, agree to pay by cheque **(Name of Caregiver/Relationship to Client)**
or cash upon each visit, unless otherwise arranged with Cheryl D. Lindsay, Speech-Language Pathologist.

In accordance to this statement, I understand that if my **account balance is outstanding $350.00** (approximately 5 sessions) and payment options have not been discussed with the Speech-Language Pathologist, **speech-language therapy for my child will be discontinued until the account balance is paid in full.** ________.
(initial)

Once the account balance has been paid, therapy will resume as arranged and agreed upon by the parent/caregiver and Speech-Language Pathologist. **Accounts outstanding for more than 60 days will be charged interest, and may be subject to referral to a collection agency.**

If you have extenuating circumstances or have questions/concerns about payment methods, please contact the office to address such issues.

SIGNATURE:____
(Parent/Caregiver)

PRINTED NAME:____

SIGNATURE:____
(Speech-Language Pathologist)

DATE:________________________________