Capitol City
Speech Therapy, LLC
141 N Main Street
Fuquay-Varina, NC 27526
1520 Glenwood Avenue, Suite 201
Raleigh, NC 27608
Office: 919-577-6807 Fax: 919-577-6853
www.capitolcityspeechtherapy.com

Permission to participate/payment terms

"M.A.G.I.C." Preschool 2017-2018

I _____give permission for my child _____
(Name of Legal Representative) (Name of Child)

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 may 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 10th of the month a 5% late fee will be added for EACH week it is late. 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. I can cancel my child's registration at any point during the year but I must provide a 30 day written notice. Without a 30 day notice I understand I will be charged an additional month of tuition. If your child is picked up late, $5.00 will be charged for each 10 minutes your child is picked up late. Money will be collected at the time of pick up.

MEDICAL AUTHORIZATION:

_____(initial) I agree that Capitol City Speech Therapy staff may administer first aid, perform CPR and authorize a physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately. I understand that all medical costs incurred are my responsibility. I release and forever discharge Capitol City Speech Therapy, LLC and the owners, contractors, agents, and employees from and against any and all liability incurred as a result of any act they may perform on behalf of my child (CPR, for example).

PHOTO RELEASE:

_____(initial) I DO I DO NOT (circle one) express permission for Capitol City Speech Therapy to exhibit photographs, and videos of _____ (name of student). Images and first names of students may be used for Capitol City Speech Therapy website, group Facebook page (secure), art projects, displayed in the office and/or other publications. I understand that this permission cannot be revoked.

PARENT HANDBOOK:

_____(initial) I acknowledge that I have received and understand the contents within the Parent Handbook for Capitol City Speech Therapy.

AUTHORIZATION FOR PICK UP:
I hereby give permission for the following person(s) to pick up my child _____from Capitol City Speech Therapy Preschool/Camp/Group services.

Name of Approved Person(s):

_____/_____
Name Relationship

_____/_____
Name Relationship

_____/_____
Name Relationship

_____/_____
Name Relationship

I understand that a photo ID will be required for my child to be picked up from Capitol City Speech Therapy.

_____Monthly Rate $225 x 2 day/week program (T/TH) 9:00-12:00 (2-3 year olds)

_____Monthly Rate $275 x3 day/week program (M/W/F) 9:00-12:00 (bring packed lunch) (3-4 yr. olds)

_____Monthly Rate $375 x4 day/week program (M/T/W/TH) 12:00-4:00 (bring packed lunch) (4 yr. olds)
Requirement: To purchase a Handwriting Book from Patti

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

_____ Extended school day $30.00 (8:30 drop off or 12:30 pick up)_____

_____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**