



FEE AGREEMENT

DOB: __/__/__

I wish to enroll _____ in Columbus Speech & Hearing Center's Program.

Office Use Only:

Type of Service: 30 min 1/week _____ Cost: \$65.00 _____

Type of Service: 60 min 1/week _____ Cost: \$130.00 _____

Type of Service: _____ Cost: \$ _____

Since regular attendance is necessary to ensure the greatest benefit from therapy, I understand I will be expected to meet with the therapist regularly. I also understand that if attendance cannot be maintained on a regular basis, therapy can be terminated.

I understand and agree to the above.

Signature Relationship Date