Voice & Swallowing Center Attendance Policy

The Voice and Swallowing Center has a waiting list of patients, so it is important that patients arrive on time and contact us if they are unable to attend their scheduled appointments. With a few exceptions, evaluation appointments are 90 min, voice therapy appointments are 30 min, and swallowing therapy appointments are 60 min.

If you are unable to attend your scheduled evaluation or therapy appointment, please contact the Voice and Swallowing Center assistant at 704.295.3345 at least 24 hrs in advance.

Please arrive 5-10 min before your scheduled appointment time so that you can have adequate time to check in and your session may begin on time. If you arrive to your session late, your session time will be shortened by that amount of time (i.e. 10 min late = 20 min therapy session). However, if you miss half of your therapy session (i.e. are 15 min late or more to a 30 min therapy session), then you will not be able to be seen that day and will have to reschedule that appointment time. If you are 30 min late or more to an evaluation appointment, that appointment will have to be rescheduled.

Failing to attend an appointment without first calling to cancel is considered a “no-show.” “No-showing” for an evaluation appointment will result in a $100 fee. Three “no-shows” or three consecutive cancellations for therapy sessions constitutes excessive absences and will result in being discharged from Voice and Swallowing Center services.

Evaluation must be completed with 90 days from the original referral from the physician. Therapy must be initiated with 60 days following the completion of the evaluation. Beyond this time frame, or if you wish to resume therapy services after being discharged for excessive absences, a new physician referral and re-evaluation by the Voice and Swallowing Center will be required.

I, ________________________________, understand that regular attendance is essential to making progress in therapy.

_________________________________________  __________________________
Signature of Patient                          Date

_________________________________________  __________________________
Signature of Therapist                         Date