Alabama A&M UNIVERSITY

Communicative Sciences & Disorders
P. O. Box 357
Normal, Alabama 35762
(256) 372-5534 Office
(256) 372-4055 Fax

SPEECH-LANGUAGE-HEARING CLINIC

Fee Payment Contract

Client Name: _____

I, _____ have read the Client Handbook and I agree to pay $_____ for evaluation and $_____ for each therapy session. I agree to pay the evaluation fee at the time that said services are provided. I will pay for therapy on the following schedule:

_____ at the time of the last weekly session
_____ on a bi-weekly basis

I am aware of and agree to abide by the rules and regulations developed by the Clinic regarding payment for services provided.

Date of Contract: _____ Parent, Guardian, Client: _____

Clinical Director: _____