



PROGRESSIONS
DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

School Visit Approval

Dear Parent (s),

Date: _____

As per your request, we will be making a school visit regarding your child:

_____ on _____ at _____ to:
Child's Name Date Time

Check one:

- Observe your child
 Attend a meeting

If you have any questions regarding the rates for this service, please contact our front office. After this service is provided, you will receive a bill from our billing department. Please be advised that you are responsible for the entire billed amount. Please note: this is often **not** a covered benefit of your health plan.

I _____ hereby certify that I have read the above information and understand that I am financially responsible for all charges.

Responsible Party's Signature

Relation to Patient

Date