

**the clinic
for
academic therapy**

4545 Bissonnet
Suite 215
Bellaire, Texas 77401
713/ 666-9343

REGISTRATION FORM

CLIENT: _____

RESPONSIBLE PARTY: _____

Address: _____

Address bills are to be sent, if different: _____

Primary Contact Phone Numbers: Home: _____

E-Mail: _____ Work: _____

Important Information: _____

Fees: _____ For DIAGNOSTIC EVALUATION (Half due at time of testing with remainder due at conference)

_____ For 45 minute tutoring session

_____ Registration fee **PER YEAR**

A late fee of \$5.00 will be added if a client's account is 30 days past due. Tutoring will be suspended until the account is paid.

TESTING DATE: _____ EXAMINER: _____

TUTORING SESSION: _____ TUTOR: _____

HOME PHONE: _____

E-MAIL: _____

CANCELLATION POLICY: Please call the tutor no later than 8:00 a.m. at home on the day of tutoring if you must cancel a morning session. Call before 12:00 noon at the clinic to cancel an after-school session. Otherwise we must charge for a session.

I AGREE TO ACCEPT THE CONDITIONS LISTED ABOVE:

RESPONSIBLE PARTY'S SIGNATURE: _____