AGREEMENT FOR PERSONAL ACADEMIC COACHING SERVICES (PACS)

Student Name: _____
(Last) (First) (MI)

We, the parents of _____ agree to have our child receive PACS services for the 20__-20__ calendar school year. We understand and agree to the following conditions:

PHILOSOPHY	• Students not diagnosed with learning disabilities or special needs may need extra support to be successful in the classroom environment. A personal academic coach provides students with challenging activities and assistance with classroom work.
SERVICES	• Period of this agreement is from _____ through _____. The student will receive two 30-minute sessions per week plus 30 minutes additional time where the coach will provide assistance individually or in the classroom. (There will be no sessions during regularly scheduled school vacations) • Accommodations will be listed and included in the student's records • Parents will receive a weekly email report detailing progress and coordination with classroom teacher. • Attendance at teacher conferences and accommodation meetings. • Prior to release of any records, all outstanding balances and fees must be paid.
OBSERVATION	• The parents give permission for the student to be observed during therapy sessions by persons invited by the therapist and/or principal.
FEES	Tuition/Fees: $50/week for _____ weeks ($25/session) TOTAL TUITION & FEES $
PAYMENT OPTIONS	• Payment Options: ___ Full Tuition Payment of $ _____ due prior to the start of TEACH. ___ Monthly payments of $ _____ due with CCA tuition. ___ Weekly payments of $ _____ due every Monday. • In case of student absence, therapists will try to reschedule times to assure weekly sessions occur. Weekly payments must be paid as if the child is present. No credit will be given for inclement weather, illness, other school holidays, and teacher workdays unless pre-approved by the administration. All accounts must be paid in full at the beginning of each week. If payment is not received, the saint will not be permitted to continue in the program. All returned checks must be redeemed in cash for the amount of the check plus a $35.00 returned check fee. Missed or unused sessions are not subject to refunds. Withdrawal from the program for any reason requires a 10% charge of the remaining balance due.

NILD Therapist :_____ Date: _____

CCA Principal: _____ Date: _____

Parent/Responsible Party: _____ Date: _____

Print Name: _____ Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____