AGREEMENT FOR TEACH

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

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

PHILOSOPHY	• Early intervention developed to meet the educational needs of young learners before they experience the frustration of learning failure is essential. • SEARCH consists of 3 tests of visual perception, 2 auditory tests, 2 tests of intermodal skills, and 3 neurodevelopmental tests. It provides norms for children 64 to 80 months of age. • TEACH consists of remedial tasks ordered from simple to complex, and organized into visual, visual-motor, auditory, body-image, and intermodal skill clusters which correspond to the elements of the SEARCH scan. • Once the SEARCH Scan has been administered by SEARCH & TEACH certified professionals, a student meets with a cognitive therapist to complete the TEACH "tasks" (55 learning activities carefully designed to address their individual needs).
SERVICES	• Period of this agreement is from _____ through _____. The student will receive three 30-minute sessions per week. (There will be no therapy sessions during regularly scheduled school vacations) • A rationale relating each task to reading, writing, and spelling • A well-defined mastery criteria applied prior to progressing the child to a more difficult tasks • 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: $75/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: _____