



The Learning Spectrum

2019-2020 School Year Registration



The Learning Spectrum 2019-2020 School Year Registration DUE to location by
 MARCH 15, 2019.

Central (Worthington) - South (Canal Winchester) - North East (Johnstown)

***Non-Refundable \$100 enrollment fee due at time of registration.**

Please select all services wanted and list payment source

Education Services	Days	Times	Tuition	Funding Source
Preschool - High School	M - F	9:00 am - 3:30 pm	\$27,900 annually	
Peer Rate	M - F	9:00 am - 3:30 pm	\$350 month	

Therapy Services	Days / Times	Rates	Funding Source
Occupational Therapy	Scheduled on individual basis	\$105 per HR	
Speech Therapy	Scheduled on individual basis	\$105 per HR	
Music Therapy	Scheduled on individual basis	\$32.50 per 30 MIN	

Behavior Health Services	Days / Times	Rates	Funding source
BCBA Consultation	Scheduled on individual basis	\$120 per HR	
ABA 1:1	Scheduled on individual basis *before, during, and after school day	\$65 per HR	Private Pay or insurance/Medicaid based

Inclusion Support Services	Days / Times	Rates	Funding source
1:1 and classroom support (off site)	Scheduled on individual basis	*See Rate Sheet ** No Registration Fee Required	
Speech Therapy	Scheduled on individual basis	*See Rate Sheet Fee Required	

Additional Offerings	Days / Times	Rates	Funding source
Individual Tutoring	Scheduled on individual basis	\$35 per HR	
Educational and IEP Consult	Scheduled on individual basis	\$105 per HR	



FACILITY UPGRADE FEE

TLS will be instituting a **facility upgrade fee for the 2019-2020 school year: \$1000 per child**, with discounts for families who have multiple children enrolled (\$500 per year child for the second and additional children).

\$100 of this fee is a non-refundable enrollment fee due with registration paperwork by March 15, 2019 (see attached services and payment source form), **the other \$900 can be paid *in full at the beginning of the school year, paid in quarterly installments of \$225 each, or paid in monthly installments of \$100 each.*** (For additional siblings: \$50 enrollment fee and \$450 paid in full/\$112.50 quarterly/\$50 monthly per child.)

Please indicate below which payment plan and method you would like to use to pay your fee:

Child's Full Name (Please Print): _____

Child's Full Name (Please Print): _____

Child's Full Name (Please Print): _____

Parent/Guardian Name (Please Print): _____

We will pay our fee:

\$900 in full, due Aug. 1, 2019

\$225 per quarter, due Aug. 1, 2019; Oct. 15, 2019; Jan. 15, 2020; and Mar. 15, 2020

\$100 per month, due the first of each month Aug. 2019 – Apr. 2020 (nine payments total)

\$450 for each additional child/\$112.50 quarterly/\$50 monthly (circle one if applicable)

Payment method:

Cash

Check (made payable to The Learning Spectrum)

Charge my credit card on file (see attached Credit Card on File Agreement)

Parent/Guardian Signature: _____ Date: _____

As always, if a family has a financial hardship, we will provide paperwork to you in order to get the financial fees reduced. Please contact your site director if you need hardship paperwork.



Child's Name: _____

Date of Birth: _____ Age: _____

Parent or Guardian: _____

Primary Phone Number: _____

E-Mail: _____

Current Address: _____

City: _____ Zip Code: _____

School District of Residence: _____

Registration Fee included Check #: _____ Staff Initials: _____

*For credit card payments see attached form
accepted by phone - call 614-844-5433

Please select location for services:

- | | | |
|--|---|---|
| <input type="checkbox"/> Central (Worthington)
122 Dillmont Drive
Columbus, OH 43235
614-844-5433 | <input type="checkbox"/> North East (Johnstown)
3060 Johnstown-Utica Road
Johnstown, OH 43031
740-759-7099 | <input type="checkbox"/> South (Canal Winchester)
122 Washington Street
Suite 401
Canal Winchester, OH 43110
614-834-1114 |
| <input type="checkbox"/> ABA Therapy/Behavioral Health
1277 Worthington Woods Blvd.
Columbus, OH 43085
614-844-5433 | | |



Credit Card on File Agreement

TLS has implemented a policy which enables you to maintain your credit card information securely on file with The Learning Spectrum. In providing us with your credit card information, you are giving The Learning Spectrum permission to automatically charge your credit card on file for your monthly tuition for any minor child(ren) you have listed on this form. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

This card will only be authorized for the use of credit card holder, and his or her minor child(ren) listed below.

Outstanding Balance: If there are any other outstanding balances owed after 30 days of service, The Learning Spectrum will notify you via phone and or email. If we do not receive a response from you or your payment in full, at that time the balance owed will be charged to your credit card. A copy of the charge will be sent by email or mail to you. This in no way compromises your ability to dispute a charge.

I authorize _____, to charge tuition and outstanding balances on my account to the following credit card:

VISA

MasterCard

American Express

Discover

Credit Card Holder's Name: _____

Credit Card Number: _____

Expiration Date: _____

CVC: _____

Child's Full Name (Please Print): _____

Child's Full Name (Please Print): _____

Child's Full Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____



Therapy Registration Scheduling Request 2019-2020

Child's Name: _____

Parent/Guardian(s) Name: _____

Phone (Primary): _____ Phone (Secondary): _____

Home Address: _____

*E-mail (Required): _____

Child's Physician: _____

My Child is currently enrolled at The Learning Spectrum:

Central (Worthington) North East (Johnstown) South (Canal Winchester)

My child attends school/ programming elsewhere; needs outpatient therapy only:

I would like for my child to receive services at the following location:

Central (Worthington) North East (Johnstown) South (Canal Winchester)

I would like for my child to receive the following services utilizing the listed funding source:

Service :	Funding Source - Please List:
Speech Therapy <input type="checkbox"/>	_____
Occupational Therapy <input type="checkbox"/>	_____
Music Therapy <input type="checkbox"/>	_____

**NOTE: if utilizing insurance/Medicaid, a copy of your card must be submitted with this form.*

My child receives additional therapy services outside of The Learning Spectrum:

Day(s): _____ Time(s): _____

Please list top three day/time preferences below if your child does not attend The Learning Spectrum or needs before/after school accommodations:

My child may receive services during TLS day/school hours

Please schedule therapies back to back

Day(s): _____ Time(s): _____

Additional Notes: _____

*Please return this form along with a copy of your insurance and/or Medicaid cards (front and back) to: Julia Jovanovic, M.A. CCC-SLP –Speech Language Pathologist/Therapy Director
therapy@thelearningspectrum.com*