CANCELLATION/ MISSED APPOINTMENT POLICY

Client Name: _________________________________ Client Date of Birth: _______________

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments, and by notifying us in advance if you are unable to do so. Thank you for your courtesy.

ALL CLIENTS WHO **<u>FAIL TO ARRIVE ON-TIME</u>** FOR THEIR SCHEDULED APPOINTMENTS OR WHO **<u>CANCEL WITH LESS THAN 24 HOURS</u>** ADVANCE NOTICED WILL BE CHARGED A NO SHOW FEE OF **<u>$65.00</u>**

Important Information:

- This no show fee is **<u>NOT</u>** covered by insurance plans and is your responsibility to pay
- If you need to cancel or reschedule an appointment, please give us at least 24 hour notice in advance to avoid a charge. You must leave a voicemail message if you do not speak to our receptionist.
- If you <u>fail to arrive</u> for your appointment, are more than <u>20 minutes late</u>, or have not notified us 24 hours in advance, you will be charged a no show fee.
- Two consecutive no show fees or excessive cancellations will result in your therapist being notified, cancellation of any remaining appointments, and your chart being closed.
- All no show fees are due at the time of your next scheduled appointment
- Our reminder service are sent as a courtesy and will not prevent these charges.

Thank you for your assistance in complying with our policy.

I HAVE READ THIS CANCELLATION/MISSED APPOINTMENT POILICY. I UNDERSTAND AND AGREE TO THIS CANCELLATION/MISSED APPOINTMENT POLICY.

____ Date: _________________

Signature of the Client or Responsible Party

____

Printed Name of Responsible Party

____ Date: _________________

Therapist Signature

Statement of Understanding:

Client *Therapist*

_____ ______ *This policy has been verbally reviewed with me by my therapist during my initial session. I understand that there are no exceptions to this policy including but not limited to: illness, emergency, work, traffic, inclement weather.*