Missed Appointment/Late Cancellation Policy

1. I understand that I may be charged a LATE CANCELLATION fee of up to $175 with the card on file if I fail to provide at least a 24-hour cancellation notice to the office by phone call.

2. I understand that I may be charged a NO-SHOW fee of up to $175 with the card on file if I fail to show for my appointment.

3. I understand that it is my responsibility to know my benefits and my financial responsibility for copayments and deductibles.

4. I understand that these charges are an out-of-pocket expense and that my insurance carrier will not cover these charges.

5. I understand that I must immediately pay the no show/cancellation fee. If I do not pay it within 30 days, a $30 late fee will be charged.

6. I understand that the card on file will be charged any fees owed without notification.

7. I understand that the therapy session will last between 53-60 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time.

8. If I am more than 10 minutes, I understand that the therapist may have already left the Zoom Video Conference Link and I will be subject to the no show fee.

9. I understand that if I miss an appointment, I must reschedule my appointment through my portal account as all of my existing appointments have been cancelled.

10. I understand that that if I miss/cancel 2+ appointments within a 30-day period, I will lose my weekly spot.

11. I understand that I will have to schedule an appointment through my portal account in the event I lose my weekly spot. If I miss any of those appointments, I will be re-directed back to my insurance to find a new provider.

12. Since we have scheduled you for the entire hour, we will be charging the difference should you begin or end your session early (no matter what the reason). This fee can range from the full session fee of $175 to $36.46.

12. I also understand a collection agency will be used in the event I do not pay my outstanding bill within 3 months and that non-payment may negatively affect my credit score.

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By signing this, I agree to the above stated terms and stipulations regarding the services I receive from this therapist.

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Signature of Client or Personal Representative

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Printed Name of Client or Personal Representative and Relationship to Client