No Show, Late Cancellation & Co-Payment Policy

Please initial by each statement indicating that you understand and agree.

1. _____ I understand that I will be charged a LATE CANCELLATION fee of $***35.00*** if I fail to give at least 24 hour notice prior to cancelling my appointment.
2. _____ I understand that I will be charged a NO-SHOW fee of ***$50.00*** if I fail to show for my appointment.
3. _____ I understand that I am responsible for knowing my co-payment amount and deductible amount.
4. _____ I understand that I will be charged a ***$35.00*** service charge if I fail to make my payment and/or co-payment at the time of my appointment.
5. _____ I understand that these charges are an out of pocket expenses and that my insurance carrier will not cover these charges.
6. _____ I understand that the therapy session will last 50 minutes unless an alternative is agreed upon by myself and my therapist. Sessions start on the hour and end 10 minutes before the next hour. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

Signature of Responsible Party _____

Printed Name of Client_____

Date _____