Ponderosa Counseling

Cancellation and Payment Policy

Patient's Name (please print): _____ Date of Birth: _____

If you must cancel your appointment, please provide at least 24 business hours notice. This will enable another person who is waiting for an appointment to be scheduled.

Once your appointment is scheduled, you will be expected to pay the full fee unless you provide notice at least 24 hours in advance. Telephone and text messages are acceptable ways to inform us of cancellation. Patients who miss their appointment without notice of cancellation will be considered a NO-SHOW. No-shows will be expected to pay the full fee. Patients who no-show two or more times in a 12-month period may be dismissed from the practice.

Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the next appointment. In special unavoidable circumstances, fees may be waived with the provider's approval. Our practice firmly believes that a good therapeutic relationship between patient and provider is based upon understanding and good communication.

Permission to Charge Credit Card

Name as it appears on credit card (if different from patient): _____

Type of Card: American Express___ Discover___ Mastercard___ Visa___

Credit Card Number: _____

Expiration Date: _____ /_____ (mm/yy) Security Code: _____

Billing Zip Code: _____

I give permission to _____to charge my credit card for professional services.

_____agrees to only charge for services rendered; or late cancellations/no-show sessions if appointment is not canceled within twenty-four business hours. (If the appointment is the day after a holiday, it should be canceled by the previous business day.)

I understand that I have the right to revoke this agreement at any time by providing a request in writing.

Please sign that you have read, understand, and agree to this Cancellation and Payment Policy.

Signature of Patient or Representative: _____ Date: _____