Payment Policy/Credit Card Consent

1. I understand that I will be charged a LATE CANCELLATION fee of $50 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 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 my therapist will charge for any balance due if I fail to provide payment.

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

6. I understand that the therapy session will last 45 minutes. 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.

_____
Client Name

_____
Name on Card

_____
Credit Card Type

_____
Credit Card Number

_____
Expiration Date

_____
Security Code

_____
Signature