

## **Nuance Neuropsychology LLC**

510 N. Washington St. Suite 300 Falls Church, VA 22046 Office: (703) 946-9048 Fax: (866) 518-7457 www.nuanceneuropsych.com

## **UPDATED CANCELLATION/NO SHOW POLICIES EFFECTIVE MARCH 2019**

Nuance Neuropsychology LLC is updating its policies due to a number of factors including a quite lengthy waiting list of patients who wish to initiate services with Dr. Caster, an increasing number of last-minute cancellations, and too many no-shows for scheduled appointments. As of <u>March 1, 2019</u>, the following policy changes will take effect:

For Individual Psychotherapy Patients:

- A valid <u>credit card must be on file</u> with our office for any patient who wishes to remain under Dr. Caster's care. If you do not feel comfortable providing your credit card information, Dr. Caster will provide you with referrals to alternative providers.
- The <u>cancellation fee</u> for scheduled <u>psychotherapy appointments</u> <u>will be \$75</u> and all cancellations must be made with <u>more than 48-hours' notice to avoid the fee</u>. If you have an appointment scheduled for Monday, you must notify our office by no later than Thursday evening (5pm) to avoid the cancellation fee so that we have time to schedule a different patient for that time.
- If you fail to attend your psychotherapy appointment as scheduled and fail to notify our office in advance of your intent to cancel, you will be responsible for a "No-Show" fee of \$100.
- Any patient who "no shows"/cancels more than twice will be provided with referrals to alternate providers.

## **Actions Requested:**

- If you receive this document via our Patient Portal, your electronic signature indicates that you are aware of the policy changes and accept the new procedures.
- If you receive this document via email, please simply respond to the email by making the subject line read: "Acknowledge and Accept Policy Changes"
- If you receive this document in paper form, your signature below affirms that you acknowledge and agree to the new terms of the policy.

Patient's/Legal Guardian's Signature	Date	
Printed Name		