

Finding Freedom Now, LLC

Angela Brettschneider, LCSW

404.354.1412

No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of one half of the session fee if I fail to give at least 24 hour notice prior to cancelling my appointment. For those with insurance, the fee will equal one half of my rate at \$130 per 50 minute session.

2. I understand that I will be charged the entire session fee if I fail to show for my appointment. For those with insurance the fee will equal my rate of \$130 per 50 minute session.

3. I understand that I am responsible for knowing my co-payment amount and deductible amount. My co-payment amount per session is _____; my deductible amount per year is _____. Have you met your deductible for this year? YES NO If no, how much more do you have to pay towards your deductible? _____

4. I understand that I will be charged a \$10 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 expense and that my insurance carrier will not cover these charges.

6. I understand that the therapy session will last 50 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.

Signature of Responsible Party

Date