



No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of \$150.00 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 \$150.00 if I fail to show for my appointment.
3. I understand that I am responsible for knowing my co-payment amount and deductible amount. 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.

*Clients must fill out item 3 prior to intake.

Signature of responsible party

Today's date (MM/DD/YYYY)