CANCELLATION AND NO SHOW POLICY

Psychotherapy sessions are made in advance and that time is reserved for you. We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, that you provide 48 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. Your therapist will make every effort to reschedule your appointment at the soonest availability.

With cancellations made with less than 48 hours notice, we are far less able to offer that slot to someone else. Office appointments, which are cancelled with less than 48 hours notification, will be subject to the full cost of the session, which will be billed to the credit card on file.

Clients who do not show up for their appointment without a call to cancel their appointment will be considered as NO SHOW. NO SHOW appointments will be subject to the full fee billed to the credit card on file.

Insurance companies do not pay for cancelled or NO SHOW appointments, therefore, incurred fees are the sole responsibility of the client to pay in full.

In the event of outstanding circumstances where the 48-hour cancellation policy is not followed, your therapist has the discretion to waive the fee after discussing your situation with you to determine if outstanding circumstances were at fault. Our practice firmly believes that quality therapeutic relationships are based upon understanding and good communication. Please address any questions you have about this policy with your therapist.

Please sign that you have read, understand and agree to this Cancellation and No show policy.

I am providing my credit card information with the understanding that this card will be charged in the event of a cancellation of less than 48 hours or if I NO SHOW an appointment. My mental health provider will inform me when submitting any charges to my card on file.

_____   _____
credit card number   exp. date

_____   _____
client signature   date

_____   _____
parent or guardian signature (if applicable)   date

_____   _____
therapist signature   date