No Show and Late Cancellation Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $25 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 $25 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 45-50 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.

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Signature of Responsible Party

____

Date