No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $60 if I fail to give at least 48-hour notice prior to cancelling my appointment.
2. I understand that I will be charged a NO-SHOW fee of the cost of my session (which is not paid by insurance) 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.
2. I understand that the therapy session will last 50- minutes (for individual and couple sessions/60 minutes for group). 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 Client /Parent/Guardian Printed Name of Client Date