



No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of \$40 if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will be charged the full session fee if I NO-SHOW or fail to show for my appointment.

- Please note that this policy cannot be applied to clients using an EAP service such as Comp Psych or Guidance Resources. Thus, clients using an EAP provider who have 2 or more late cancellations or missed sessions will be referred to other providers in the area.

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.



L.V. Doubleday
COUNSELING

Signature of Responsible Party

Date

