Art of Therapy Center
A holistic approach to therapy with families.

No Show, Late Cancellation and Co-payment 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 I am expected to arrive 30 minutes before your intake/evaluation appointment to be registered and check in. Please arrive 15 minutes early for all follow ups to ensure your appointment starts on time.

4. I understand I am expected to arrive before the appointment time for my intake/evaluation appointment or by no later than 10 after the appointment time for follow up appointments or my appointment will automatically be rescheduled.

5. 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?_____

6. 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.

7. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

8. I understand that the therapy sessions will be scheduled for 60 minutes {Sessions can last anywhere from 20-60 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.

_____

Signature of Responsible Party

_____

Name of Responsible Party

_____

Date