NO SHOW/CANCELLATION POLICY AGREEMENT

Psychological Strategies, LLP has a **very strict no show/ late cancellation policy**. Because the appointment time is reserved for you, it is necessary to charge the patient for appointments which are not cancelled ______ hours in advance**. Initial: ____________ ___________**

Failure to provide this advance notice generally means that we are not able to use the appointment time. Insurance companies cannot be billed for these lost appointment times and, therefore, it will be the patient's responsibility to pay the designated office fee of $50.

I have read the above material and agree to the terms.

____ __________________

Patient/Parent/Guardian Signature Date

____ __________________

Patient/Parent/Guardian Signature Date

____ __________________

Therapist Signature Date

Patient Name: _________________________________ Patient ID _____________________