## NO SHOW / SAME DAY CANCELATION POLICY

Patient Name: ______________________________ Date: ________________________

In order to ensure we are maximizing our appointment availability for all patients, it is important that you show up for your appointment at the date and time it is scheduled. Not showing up for an appointment or canceling last minute does not allow for us to fill this appointment slot with another patient. Please keep your records up to date in order to avoid any miscommunications with this clinic.

**NO SHOW:**

A No Show is when you fail to show up for your scheduled appointment. You will be charged a no-show fee of $50 for therapy appointments and $100 for medication appointments. *Reminder calls are a courtesy only*; you are responsible for attending or notifying our office of any changes or cancelations to your appointments.

**SAME DAY CANCELATIONS:**

We request that you contact our office within one (1) business day of your appointment if you need to cancel or reschedule. Calls or messages received the day of the appointment are considered a same day cancelation. We will attempt to reschedule you for the next available appointment, but you will still be charged a same day cancelation fee of $50 for a therapy appointment and $100 for a medication appointment.

**If you have 2 or more same day cancelations or missed appointments, we reserve the right to not reschedule you for any more appointments. All fees must be paid before we will consider rescheduling you for any further appointments**

**LATE ARRIVAL:**

- Therapy appointments last approximately 50-60 minutes. If you are 15 minutes late for your appointment, your session will end at the regularly scheduled time in order to accommodate other patients OR your appointment may be canceled and you will be charged a late fee.
- Medication appointments general last from 20-30 minutes. If you are more than 10 minutes late for your appointment, you will be asked to reschedule and will be charged a no-show fee for that appointment.

Patient Name (Print) ____________________________________

Signature of Patient: ____________________________________ Date: ____________________

Signature of Parent/Guardian: ____________________________ Date: ____________________

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