

The Center for Healing
Indigo Wisdom Professional Counseling, LLC

No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of \$75.00 if I fail to give at least a 48-hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of \$75.00 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? _____

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

5. I understand that the therapy session will last 45 – 60 minutes depending upon the type of insurance. 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.

Date

Signature of Responsible Party