Ponderosa Counseling Center, LLC

Patient Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. IT IS THEREFORE REQUESTED THAT IF YOU MUST CANCEL YOUR APPOINTMENT YOU PROVIDE MORE THAN 24 HOURS NOTICE. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Appointments which are cancelled with less than 24 hours notification will be subject to a $100 cancellation fee. Patients who do not show up for their appointment without a call to cancel an appointment will be considered a NO SHOW. No Shows will also be subject to a $100 fee for the appointment. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived, but only with the provider's approval. Our practice firmly believes that good therapeutic relationship between patient and provider is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____ _____

Patient's Name (print): Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

Permission to Charge Credit Card

Name of person responsible for payment: _____

Name as it appears on credit card if different from above: _____

Type of Card:
American Express__
Discover__
Visa__
Mastercard__

Credit Card Number: _____

Expiration date: __/__ (mm/yy)

Security Code:_____

Billing address associated with card:

Street: _____
City:_____ State:_____ Zip Code:_____

I give permission to _____to charge my credit card for professional services. _____ agrees to only charge for services rendered; or late cancellations/no show sessions if appointment is not canceled within twenty four working hours. (If the appointment is the day after a holiday, it should be canceled by the previous working day at noon).

I understand that I have the right to revoke this agreement at any time by providing a request in writing.

Signature:_____ Date: _____

**The office will periodically request credit card information as needed.