Leslie Ellen Ackerman, Psy.D., PC

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ARA PSYCHOLOGICAL ASSOCIATES CANCELATION POLICY

To All Patients:
Part of the therapy process that is extremely important is continuity. Our goal is to set a time with you that you know you can make regularly and to keep those appointments in order to be able to effectively focus on your treatment and progress often made by working toward specific goals we set together. In particular, appointments from 8:00 am to 10:00am and 4:30 to 8:00 pm are at a premium and there are constant requests for these dates either as a regular date or to make up an appointment from a similar time slot. When regularly scheduled patients miss appointments in that time frame, it not only loses a spot I could have filled, it is a disservice to another patient that, with notice, would have been delighted to take an open spot. For these reasons, we have a firm cancellation policy outlined below.

All appointments must be canceled within 24-hours of the appointment time. For Monday appointments, notification should be given before 3:00pm on the preceding Friday. You will not be charged for cancelled sessions, so long as you adhere to this policy. On the other hand, I will have to charge you for the appointment hour if you miss a session or cancel without the required notice. Given that insurance companies do not always pay for missed or cancelled sessions, you will be responsible for the full fee for such sessions regardless of coverage. In this event, you will be charged a **$150 cancelation fee**.

As a part of our cancellation policy, we require a credit card to be kept on file which we will charge for cancellations as well as co-pays not paid at the time of your appointment. Your signature below gives us permission to charge any outstanding charges to your card at the time such charge(s) are due. Missed appointments are charged to your card directly and **not** to your insurance company. **All such charges** are your responsibility to pay at our standard rate. We cannot proceed with you as a patient without a credit card on file or some other form of deposit which we will gladly discuss with you. The card provided must be either a card in your name or, if you are a legal guardian of the patient, it should be in your name.

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By signing in the space provided below I am authorizing ARA Psychological Associates/Dr. Leslie Ackerman to charge my credit card for any Co-Pay I do not pay at the time of service and for any appointments canceled as defined in the above cancellation policy. I understand that my card will be charged and a notice will subsequently be emailed to me advising me as to the nature of the charge(s).

Card provided must be in same name as Patient unless Patient is a minor.

Name On Card: _____

CARD# _____

Date of Expiration _____

CVV Code _____ (4 digits on front of Amex, 3 digits on back of Visa/MC)

Relationship to Patient if not patient's card: _____

_____
Cardholder Signature/Date