

CANCELLATION AND PAST DUE POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another patient and you will be billed for the cost of your missed appointment.

A missed session fee of $70 will be charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. **This includes missing your scheduled intake appointment.** Documentation may be required in order to avoid the fee. A credit or debit card is required to be kept on file and will be charged **one week** from the appointment date unless an alternative payment arrangement is made.

**This card will also be used to charge any past due amount owed unless alternative payment arrangements are made.** A good faith effort will be made to resolve any past due amount prior to taking this step. You will be notified prior to any charge made to your card.

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Jamron Counseling to use my credit card information to charge my credit card in the event that I do not notify my therapist of my inability to attend scheduled therapy appointments and/or do not cancel my appointment at least 24 hours in advance and/or to settle any past due balance that is owed, or if a check is returned for any reason. I will not dispute charges (“charge back”) for sessions I have received or appointments I have missed according to the above policy.

Card Type (circle one): VISA MasterCard Discover American Express

Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verification/Security Code (3 digit code on back of card by signature line): \_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below I am authorizing Jamron Counseling to charge for missed scheduled appointments.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_