Psychotherapy Appointment Policy

I understand that I have reserved a regular psychotherapy time for a particular day, time and frequency, and agree that if I am unable to come in for my regularly scheduled appointment, I will provide as much notice as possible, with a minimum 24-hour notice.

I understand that psychotherapy appointments missed without notice, will be assigned a $100 charge. I understand that missed appointments cannot be filed with my insurance, and that I will be solely responsible for these charges.

I understand that multiple missed appointment and/or failure to cover balances in a timely manner may result in the closing of my therapy chart.

______________________________ Patient Name

______________________________ Name of Responsible Party (if not the patient)

______________________________ Signature of Responsible Party/Patient

*Digital Signature

______________________________ Signature of SPA staff/witness

______________________________ Date