Cancelation Policy

1. I understand that I will be charged a **late cancelation fee** of $180 if I fail to give at least 24 hour notice prior to cancelling my appointment. I understand that I will not be charged if I am ill or if my child is ill, or if there is a true act-of-god that prevents me from keeping my appointment.

2. I understand that I will be charged a **no-show fee** of $180 if I fail to show for my appointment.

5. I understand that these charges are an out-of-pocket expense, not covered by insurance nor allowable under my HSA account.

6. I understand that the therapy session will last 45 minutes. 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.

_____Signature of Responsible Party

_____
Date