No Show, Late Cancellation and Co-payment Policy

Rayford Therapeutic Institute of Counseling, Education, and Wellness

1. I understand that I will be charged a LATE CANCELLATION fee by Rayford Therapeutic Institute of Counseling, Education, and Wellness, of the entire billable session if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of the entire billable session if I fail to show for my appointment.

3. I understand that I am responsible for knowing my co-payment amount and deductible amount. My co-payment amount per session is __N/A____; my deductible amount per year is ____N/A_____. Have you met your deductible for this year? □YES □ NO If no, how much more do you have to pay towards your deductible?___N/A_____

4. I understand that I will be charged a $10 service charge if I fail to make my payment and/or co-payment at the time of my appointment.

5. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

6. I understand that the therapy session will last 30 minutes if teletherapy, and 60 minutes if in-person. 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