Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full fee is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment. Thank you for your consideration regarding this important matter.

It is also understood that in the event that you do not show for two scheduled appointments, you will be dismissed from the practice and asked to seek counseling care elsewhere. Upon a dismissal, you will only be allowed to be seen in the office within 30 days in an event of an emergency and will be unable to schedule any further appointments with the practice.

Client's Signature____ Today's Date ______________________

Payment Agreement

The client is responsible for payment of any counseling services that are not covered by any health plan/insurance company including co-payments, co-insurance, and deductible. That client further understands that if they do not have an in-network health insurance, they will be responsible for payment, which is due at the end of each visit. Payment for services may be paid at each appointment by cash or personal check.

The client understands that professional services are rendered to a person, not an insurance company. Hence, the insurance company is responsible to the client and the client is responsible to the counseling practice. Therefore, regardless of the insurance status, the client is ultimately responsible for the balance on their account for any professional services rendered. The client is responsible for any collection agency or attorney fees required to settle any delinquent account balance.

By signing, the client agrees to the above payment criteria and allows for the release of any counseling notes/records to the respective health plan/insurance company and its agents of any information needed to determine these benefits or the benefits payable to related services. This authorization is valid until revoked by the client and/or termination of services. In the event that Trish McCoy accepts assignment on my claim, the client requests that payment of authorized benefits be made payable to her.

I understand and consent to the assignment of benefits, payment responsibilities, and disclosures above.

Client's Signature____ Today's Date ______________________

Acknowledgement and Consent

I certify that I have read and understand the above information and that information is true and correct to the best of my knowledge. I will notify Trish McCoy, of any changes in my health status, insurance coverage, address/phone number and/or the above information.

Client's Signature____ Today's Date ______________________