Blumberg Family Therapy Group, Inc.

NO-SHOW AND CANCELLATION POLICY

This is my declaration of agreement regarding missed or cancelled appointments. I understand and agree to the following:

1. It is my responsibility to notify my clinician at **Blumberg Family Therapy Group** at least 24-hours prior to the scheduled appointment if I am unable to keep the scheduled appointment. _____Initials

2. I agree that I will be billed the insurance contracted rate or the regular fee if I pay out of pocket in the event that I miss an appointment or fail to cancel at least 24-hours prior to the scheduled appointment._____Initials

3. If I violate this policy, I agree to be charged for the session automatically by credit card (complete below)._____ Initials

Patient: _____

Clinician: _____

Date: _____

Type of Card: VISA ❒MasterCard ❒ Exp. Date: _____/_____

Card Number: _____-_____-_____-_____

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

Billing Address:_____

City:_____ State: _____ Zip:_____