CANTERBURY COUNSELING CENTER
FINANCIAL INFORMATION

24-HOUR CANCELLATION OR NO SHOW APPOINTMENT POLICY

I understand and agree to the following:

1. It is my responsibility to notify my counselor or the office staff **24-hours prior to the scheduled appointment time if I am unable to keep my appointment.** I will leave a message on CCC voice mail after hours if necessary or if phone lines are busy.

2. At the discretion of my therapist, I agree that I will be billed my insurance or EAP company's contracted rate or the agreed upon fee in the event that I fail to cancel **24-hours prior to the appointment.**

3. **In the event that I do not call to cancel my appointment at least 24 hours in advance, any future scheduled appointments will be CANCELLED.** I acknowledge that I may return to services by paying the fee for not showing for my appointment and calling to schedule the next available appointment.

_____ **Date**_____
Client's Signature