Mental and Emotional Wellness Centers of Ohio

No Show, Late Cancellation and Co Payment Policy

Name:
Date of Birth:

1. I understand that I will be charged a **LATE CANCELLATION fee** of **$35**. 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 **$35** 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 _____; my deductible amount per year is _____.

Have you met your deductible for this year?

□YES

□ NO

If no, how much more do you have to pay towards your deductible?_____

4. I understand that I will be charged a **$50** 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 **45 – 60** 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.