Trish J. Nauss, LCSW-R

A Different View Psychotherapy LCSW PLLC

Individual & Couples Therapy

CANCELLATION/NO SHOW & FINANCIAL POLICY

Thank you for being a valued client of my practice! As a therapist I am committed to providing my clients with exceptional care. That being said, all of my clients are equally important to me and need equal time in their treatment. When a client cancels a scheduled session without providing me with enough advanced notice or simply does not show, it prevents me from being able to provide consistent care for you or other clients in need during that time.

I understand things arise that may prevent a client from attending a scheduled session and in such cases all I require is at least **48 hours notice prior to the scheduled session** to ensure consistent care for you and all clients.

In the event you must cancel a session, please call me on my office cell **As Soon As Possible**. My voicemail is available 24 hours/7 days a week at **631-339-1326**. Please **DO NOT Email me** to schedule, change or cancel sessions as it is not a protected form of communication, is not checked regularly and may cause delays in contact; resulting in late fees for you.

In the event that a client does not provide me with the required cancellation notice of 48 hours prior to their scheduled session, you will be charged **YOUR FULL SESSION FEE.**

Credit Card On File:

I require a credit card on file for late cancellations/No Shows and any balance due past 30 days that go unresolved for an extended period of time or should you be lost to contact. You will be required to provide me with a valid credit card at the time of your Intake and expected to update me with a new card should this card become invalid at any time during treatment. Your card will be stored securely and you will receive a receipt for any charges made to your card. ***Please note*** that I will never charge this card without first making several attempts to contact you to resolve the payment issue and I will only charge it as a last resort should you be lost to contact. In the event that you are lost to contact and payments due have not been collected and there is a problem with your card on file, as a final attempt your payment due will be sent to a collection agency. In the event that you make an effort to resolve the issue and we come to an agreement, any charges can be paid by:

Payment types accepted include: cash, checks payable to: cash or A Different View Psychotherapy, and electronic transactions (through secure smartphone applications) including: debit/credit card, HSA/FSA

There is **no charge** for a cancellation or session change if it is done prior to 48 hours of a scheduled session. I will make every effort to reschedule your session for as soon as possible thereafter.

In the event of an **unforeseeable emergency**, I only ask that you contact me as soon as possible to discuss waiver of cancellation fee, which will be made at my discretion and could include waiving the full fee or only part of the fee dependent upon the nature of the situation and reason for missing a scheduled session without cancelling in advance according to this policy.

Please note that continuous cancellations or No Shows could result in termination of your treatment at which time I will assess the situation and make referrals as appropriate/necessary.

As I will always try to understand life situations that could lead up to cancellations, I hope you can also understand the value of my time as I value your time when it comes to scheduling/cancelling sessions and my policy with which you are agreeing to by signing this form and providing credit card information prior to the start of your treatment with me.

By signing this form, I______________________________________understand and agree to this
(Print Name)
Cancellation/No Show & Financial Policy and grant you permission to charge **My Full Session Fee** to my credit card which is provided on this form and to be photocopied for the required fee in the event that I violate this policy according to the terms described above. I understand that my card on file will not be charged as long as I make an effort to resolve any outstanding payment issues with (Patricia)Trish J. Nauss, LCSW-R promptly. I understand that my credit card on file will be charged in the event that I owe payment for any outstanding balances on services rendered or late cancelled/no showed sessions and I do not keep open communication regarding resolutions to the issue or I am lost to contact and if this card on file is no longer valid; in such cases, I may be sent to a collection agency for payments due. I also understand continued cancellations/No Shows could result in termination of services.

Client Signature____Date_______________

Signature of witness: (Patricia)Trish J. Nauss, LCSW-R__________________Date_______________

PLEASE INITIAL, FILL OUT ALL REQUIRED INFORMATION AND SIGN BELOW:
______I authorize the following credit card for aforementioned payment fees and understand I can change this form of payment at any time as long as I provide prior notice to Trish J. Nauss, LCSW-R and a new valid credit card.

TYPE OF CREDIT CARD____
CARD HOLDER NAME____
CREDIT CARD NUMBER____
EXPIRATION DATE____
3/4-DIGIT SECURITY CODE____
EMAIL FOR RECEIPT____
CARD HOLDER'S SIGNATURE________________________________DATE________

PHOTOCOPY OF BOTH SIDES OF CARD TO BE ATTACHED TO THIS FORM: