
# NO/SHOW LATE CANCELLATION POLICY

Flourish Counseling Center appreciates and respects your time and commitment toward the treatment process, We ask that you would extend the same consideration once an appointment or series of appointments have been scheduled. It is important to attend appointments as scheduled to optimize the benefits of counseling.

**Flourish Counseling Center maintains the following cancellation policy:**
You must provide our office with 24 hours notice to cancel an appointment without the assessment of a cancellation fee. Cancellations that are less than 24 hours due to a family medical emergency, family member death, or personal sudden illness may be rescheduled without a late cancellation fee. All other instances of a "late cancellation" or a "no show" will require the payment of a $75 fee the first time, and payment of a full session fee for any other occurrences. This will be charged to your credit or debit card on the date of the appointment.

**Please provide the following information:**
Credit Card Company (Please circle one): Visa Card Master Card Bank Debit Card
Name as it appears on the card:_____
Card Number:_____
Card Verification Number (3 digit number located on the back of the card):_____
Expiration Date: _____

Your signature below indicates that you have read and understood the Cancellation Policy of Flourish Counseling Center and agree to pay the late cancellation of No Show fee as indicated above by credit or debit card in the amount of $75 the first time and a full session fee for any other "late cancellation/ no show" and that the account listed above will be charged per the policy described.

If you do not wish to keep a credit or debit card on file, you may choose to keep a balance of $75 in reserve with Flourish Counseling Center to cover a late cancellation or no show per the cancellation policy. A cash payment of $75 is the only form of payment that is acceptable to keep in reserve.

Thank you for your cooperation with this policy. It is intended to recognize our mutual commitment to your success or the success of your family member(s) in therapy.

**Client/Guardian Name:**_____

**Signature:**_____ **Date:**_____

***But I am like an olive tree flourishing in the house of God; I trust in God's unfailing love for ever and ever. ~Psalm 52:8***

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