APPOINTMENT POLICY WITH CREDIT CARD AUTHORIZATION
Costa Provis, LCPC, NCC, CPC

TERMS AND DEFINITIONS

- **Scheduled appointment**: Time you have scheduled with your therapist for an appointment
- **24 Hour Advance Notice:** Providing your therapist 24 hour advance notice that you will **NOT** be able to attend a scheduled appointment
- **No Show/No Call:** Failure to provide notice to your therapist that you will be missing your appointment and/or not showing up for your scheduled appointment with your therapist
- **Client:** Person who is working with the therapist for professional services

APPOINTMENT POLICY

Due to the high number of clients Costa Provis meets with on a regular basis, it is the policy of your therapist that you (the "client") provide a minimum of 24 hour advance notice if you need to cancel an appointment. The tool for contacting your therapist when needing to cancel or reschedule an existing appointment will be the telephone, using the contact number provided to you by your therapist. It is acknowledged that sudden illness, emergencies, and other reasonable causes may result in missing an appointment and the therapist will exercise discretion with regard to such situations.

In the event that you (the "client") No Show/No Call or do not provide a minimum of 24 hour advance notice for your scheduled appointment, you will be charged the full rate for your scheduled session. Additionally, if you are using insurance to pay for therapy, your missed appointment will not be billed to your insurance. Instead, you will be responsible for self-paying for your missed appointment.

Please be advised that missing two consecutive appointments may result in the suspension of professional services.

By initialing the box below to the right of the arrow, you (the "client") signify that you agree with and understand this policy.

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AUTHORIZATION TO COLLECT PAYMENT USING YOUR CREDIT/DEBIT CARD

By providing the information requested below and affixing your signature with the date, you agree to allow your therapist to charge your credit/debit card the full amount for scheduled and/or missed appointments (when you fail to provide 24 hour advance notice of an appointment cancellation or when you no show/no call for a scheduled appointment). This authorization may be revoked at any time with your written consent.

Card Type: VISA MASTERCARD DISCOVER

Card Number: _____-_____-_____-_____

Exp Date: _____/_____

3 Digit security code (back of card): _____

Name on card: _____

Billing address: _____

City, State & Zip code: _____

Email Address: _____

Signature: _____ **Date:** _____