



INTEGRATED WELLNESS AND STRATEGIES, LLC

Amber W. Pearson, MA, LPC, EMDR-CT

Your path to healing and transformational growth...

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CANCELLATION & NO SHOW POLICY

I look forward to working with you in therapy. Part of commitment to therapy is making sure your sessions occur as scheduled. Please understand that any cancellations and/or no shows can delay our positive work together and are thus discouraged. The following guidelines will ensure that you get the most of your treatment:

- I will not call you the day before an appointment to remind you of it, as I believe it is your responsibility to keep track of your appointments.
- I will inform you as soon as possible ahead of time if I need to reschedule your appointment.
- Whenever possible, please give at least a 48 hour notice if you need to cancel your scheduled session.
- If you are going to be *less than 15 minutes* late for your appointment and are on your way, please call to notify me of your expected arrival time. If this occurs, I may not be able to provide you with the entire session time, but my fee for the session will remain the same.
- A **"Late Cancellation"** is if you cancel less than 24 hours before your session, you will be charged your full 50-minute individual therapy session fee of \$50.00. For insured clients, this is the equivalent of your co-pay plus what your insurance company would have paid me. Please keep in mind, this Late Cancellation fee is not covered by insurance and must be paid out of pocket.*

Initials _____

- A **"No Show"** is if you do not show up to a scheduled appointment, or arrive at an appointment later than 15 minutes past the scheduled appointment time. In this instance, you will be charged your full 50-minute individual therapy session fee of \$50.00. For insured clients, this is the equivalent of your co-pay plus what your insurance company would have paid me. Please keep in mind, this No Show fee is not covered by insurance and must be paid out of pocket.*

Initials _____

- Amber W. Pearson, MA, LPC; Integrated Wellness and Strategies, LLC; its staff and its billing agency will keep your credit card information on file in order to collect a fee in a timely manner if a Late Cancellation or No Show occurs. If you do not have a credit card, or your credit card information is inaccurate, you will be sent a bill.

Name on Credit Card: _____ Credit Card Number: _____

Expiration Date: _____ CVV Code: _____ Zip Code Associated w/ Card: _____

Street Address Associated w/ Card: _____

** Note: Cancellations with less than 24-hour notification due to illness, emergency situations, transportation issues, or inclement weather will be considered on a case-by-case basis and may not be charged a fee.*

By signing below, you agree that you have read, understand, and agreed to the above CANCELLATION & NO SHOW POLICY. In addition, you agree to pay out of pocket any charges that incur as a result of a No Show or Late Cancellation.

Client Name (printed)

Client Signature

Date

Copy provided to client.