CHANGE WITHIN REACH
TOGETHER WE CAN MAKE CHANGE POSSIBLE

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PAYMENT FOR SERVICE AND FEE ARRANGEMENTS

Co-pay and/or co-insurance for session: $_____

Payment for session not covered due to deductible: $_____

Self-pay for session when paid out-of-pocket: $_____

Charge for cancellation without 24 hours' notice: $_____

Other charges [specify]: _____ $_____

****Note: When a deductible applies, our staff will provide the exact charges for each visit in advance.**
Patients are expected to pay for services at the time services are rendered. We accept cash, checks, and all major credit cards.

ATTENDANCE POLICY

This policy outlines the expectations, procedures, and requirements regarding the late cancellation or no-show for a scheduled and confirmed therapy session with a CWR Therapist.

Cancellations and Rescheduled Appointments

Appointment cancellations may need to occur in certain circumstances; however, patients within CWR are expected to attend each scheduled session on time. A cancelled or no-showed appointment has a direct negative impact on patient treatment and on continuity of care. Since patient appointments involve reserving a time that is specifically for you, and out of respect for your therapist and other clients, a minimum of 24 hours' notice is required for rescheduling. Frequent cancellations (3 or more in a 6-month period or 2 consecutive) will result in termination of treatment.

Fees for No-Shows & Late Cancellations for All Patients (excluding Medical)

No-Show Fees: Anytime you fail to attend a scheduled appointment without giving appropriate prior notice of cancellation, you will be charged $100 for the no-show session. The credit card information or other payment information you previously provided will be used to process this payment. By providing us with your credit card information or booking an appointment, you consent to this policy. Multiple no-shows will result in termination of therapy.

Late Cancellation Fees: Any session missed by canceling less than 24 hours in advance will be charged a $100 fee. You will be charged even if the cancellation is work related and even if you rescheduled the appointment. The credit card information you previously provided will be used to process this payment. By providing us with your credit card information or booking an appointment, you consent to this policy. Repeated late cancellations (more than two) may result in termination of therapy.

Example:

A fee of $100 will be charged when you miss or cancel an appointment without giving 24 hours advanced notice. This means that if an appointment is scheduled for 3:00pm on a Tuesday, notice must be given by 3:00pm on a Monday at the absolute latest. You can cancel your appointment directly with your therapist.

Wait Time for All Patients (excluding Medical)

Your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that you arrive on time for your appointments. If you are more than 15 minutes late to your appointment, we will have no choice but to reschedule your appointment and you will be responsible for the $100 fee of a no-show. To avoid paying no-show fees, we require at least 24 hours' notice for all cancellations. If your therapist is more than 10 minutes late for the appointment, you will not be charged a fee.

No-Shows & Late Cancellations for Medical Patients

When a patient no-shows it means the patient did not make contact with the therapist before the scheduled appointment, and did not come. Late cancellations are when a patient calls within 24 hours to cancel or reschedule an appointment. For Medical patients cancellations (3 or more in a 6-month period or 2 consecutive) will result in termination of treatment and referral to a different provider.

Wait Time for Medical Patients

Your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that you arrive on time for your appointments. If you are more than 10 minutes late to your appointment, we will have no choice but to reschedule your appointment and count the appointment as a no-show.

THANK YOU!

We value you as a patient and are looking forward to supporting you in your treatment! We can only accomplish this with your commitment to consistent attendance. Thank you for your understanding.

ABOUT RECURRING CREDIT CARD CHARGES

I, _____, authorize Change Within Reach, Inc. to charge my credit card _____ for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____	_____	_____
Signature of Patient (or authorized representative)	Patient Name (please print)	Date
_____	_____	_____
Signature of Parent or Legal Guardian (if Patient is under 15)	Name of Parent or Legal Guardian (please print)	Relationship