Psychotherapy Associates of Tampa Bay L.L.C

Declaration of Agreement Regarding Missed or Cancelled Appointments

I, _____, understand and agree to the following:
Name of Patient

1. It is my responsibility to notify my treatment provider if I am unable to keep my scheduled appointment by calling either calling (888) 636-1306 and/or sending an email to Jessica@therapywithjessica.com ***at least 24 hours prior*** to my scheduled appointment. I acknowledge that I may leave a confidential voicemail message if I cannot contact my provider directly.

2. I understand that I will be billed a missed or late cancel fee **of a minimum of $75 (seventy-five dollars) up to the cost of a full self-pay fee** if I miss an appointment or fail to cancel 24 hours prior to my scheduled appointment. I also acknowledge that I may be asked to complete a *Permission to Charge Credit Card* form at the time so that my provider may keep my credit card information on file should I incur such a charge.

3. I understand that my insurance plan and/or Employee Assistance Program (EAP) will not pay for missed appointments and that it is my responsibility.

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

☐ I have been provided with a copy of this form for my records.

☐ I decline to receive a copy of this form for my records.