CANCELLATION POLICY

There is a 24-hour notice required for all cancellations. **If I do not receive 24-hour notice or you no show for a session, you will be charged $100. Please note that I have a 24-hour voicemail system for leaving messages. Note that I CANNOT pay this fee using insurance.**

I have read and understand the cancellation policy stated above.

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I authorize Michelle Warren Therapy to keep my credit card on file, to be charged $100 in the event of a late cancellation (less than 24-hour notice) or a no-show for a session. Should my credit card information change, I will update Michelle Warren Therapy with the new details promptly.

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signature date

Card Type \_\_\_\_\_\_\_\_\_\_ Name on the card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I also give permission to have Michelle Warren Therapy charge my credit card (above) for each session, which I have elected to keep on file for such purpose. \_\_\_\_\_\_\_ client initial

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I give permission to have Michelle Warren Therapy charge my **HSA card** after each session, which I have elected to keep on file for such purpose. \_\_\_\_\_\_\_\_\_\_\_ client initial

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Card Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name on the card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code \_\_\_\_\_\_\_\_\_\_\_ Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Consent to Treatment**

I am signing in agreement to receive therapeutic services from Michelle Warren Therapy

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(Client Name) Print (Date) (Signature )

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Therapist Signature ) (Date) (Signature)

Per the notice of Privacy Policy and the Psychotherapy Services Agreement, I recognize that electronic communications (email or text messaging) are potentially non-secure methods of communication. By signing below, I authorize Michelle Warren Therapy to contact me electronically. Please let Michelle Warren Therapy know immediately if you do not wish to receive any electronic forms of communication. Note that you are required to sign this part of the agreement in order to receive treatment.

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(Signature) (Date)