



Dr. Angela Reiter & ASSOCIATES CANCELLATION POLICY

To All Patients:

Part of the therapy process that is extremely important is continuity. Our goal is to set a time with you that you know you can make regularly and to keep those appointments in order to be able to effectively focus on your treatment and progress often made by working toward specific goals we set together. In particular, appointments from 8:00 am to 10:00am and 4:30 to 8:00 pm are at a premium and there are constant requests for these times either as a regular date or to make up an appointment from a similar time slot. When regularly scheduled patients miss appointments in that time frame, it not only loses a spot I could have filled, it is a disservice to another patient that, with notice, would have been delighted to take an open spot. For these reasons, we have a firm cancellation policy outlined below.

All appointments must be cancelled within 24-hours of the appointment time. For Monday appointments, notification should be given before 3:00pm on the preceding Friday. You will not be charged for cancelled sessions, so long as you adhere to this policy. On the other hand, I will have to charge you for the appointment hour if you miss a session or cancel without the required notice. In this event, you will be charged a \$100 cancellation fee.

As a part of our cancellation policy, we require a credit card to be kept on file which we will charge for cancellations as well as co-pays not paid at the time of your appointment. Your signature below gives us permission to charge any outstanding charges to your card at the time such charge(s) are due. We cannot proceed with you as a patient without a credit card on file or some other form of deposit which we will gladly discuss with you. The card provided must be either a card in your name or, if you are a legal guardian of the patient, it should be in your name.

By signing in the space provided below I am authorizing Dr. Angela Reiter & Associates to charge my credit card for any appointments cancelled as defined in the above cancellation policy. I understand that my card will be charged and a notice will subsequently be emailed to me advising me as to the nature of the charge(s).



Card provided must be in same name as Patient unless Patient is a minor.

Name On Card: _____

CARD# _____

Date of Expiration _____

CVV Code _____ (3 digits on back of Visa/MC, 4 digits on front of AMEX)

Billing Zip _____

Relationship to Patient if not patient's card: _____

Cardholder Signature/Date