ELANA M. GOTTFRIED, LMSW, ACSW
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Livonia, MI 48150
Phone (734)421-2840 Fax (734)421-4045

No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $140 if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of $140 if I fail to show for my appointment.

3. I understand that I am responsible for knowing my co-payment amount and deductible amount. My co-payment amount per session is _____; my deductible amount per year is _____. Have you met your deductible for this year? □YES □ NO If no, how much more do you have to pay towards your deductible?_____

4. I understand that I will be charged a $10 service charge if I fail to make my payment and/or co-payment at the time of my appointment.

5. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

6. I understand that the therapy session will last 50 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

_____
Signature of Responsible Party

_____
Date