



NO-SHOW/CANCELLATION POLICY

To our valued clients,

Missed and cancelled sessions pose issues for both you and your therapist. Therapy can be challenging at times and as a result there are times when it may feel easier to avoid coming in for treatment. Please speak to your therapist about this rather than missing your session. Additionally, unlike other medical offices where you may wait for up to an hour or more for a scheduled appointment, each patient has their own scheduled appointment time at our office. It is extremely difficult to fill a session time when a cancellation happens with short notice.

The policy at Hawaii Anxiety and Trauma Care is as follows:

You will be charged \$100 for missed appointments or appointments that are cancelled with less than 24-hours' notice unless it is possible for our therapists to find another time to reschedule your appointment within the same week. If rescheduling is possible, you may do so at no additional fee. Please note that fees for missed sessions cannot be billed to health insurance plans.

After three late cancellations (less than 24 hours), or two missed ("no-show") appointments, you may be put on "walk-in" status. "Walk-in" status means that you must call the day before or the morning of the day that you would like to have an appointment and your therapist will schedule you if there are openings available. This policy is necessary for our practice to run smoothly, but it does not mean that we don't want to see you. "Walk-in" status will be removed after consistent appointments and/or at the discretion of your therapist.

Lastly, we do utilize an automated reminder service which will send a reminder (text or email) the day before your appointment. However, there may be times when the reminder is not sent, i.e. technical difficulties, and therefore you do not receive the reminder. Please be advised that it is still your responsibility to come to the appointment despite not receiving the reminder. Thank you for your help in working with us to operate a successful practice.

Your signature below indicates that you have read the No-Show/Cancellation Policy, have received a copy, and agree to abide by its terms during our professional relationship.

Printed Name of Client

Client Signature (or guardian if a minor)

Date

Psychologist (Witness)

Date

