Smith
PSYCHOLOGICAL SERVICES
smithpsychologicalservices.com

Home Office
1401 Airport Pkwy, Suite 240
Cheyenne, WY 82001

Branch Office
1635 Foxtrail Dr
Loveland, CO 80538

Tel: 307-632-7771

Cancellation, No-Show, and Termination Policy

By signing below, I acknowledge and agree that if I must cancel an appointment, I will do so before the close of business on the day prior to my appointment (5 PM) by calling the office at 307-632-7771. I also agree to leave a message if no one answers and understand that voice message time stamps will be used to determine the cancellation time. I acknowledge and understand that if I miss an appointment without cancelling, either due to no-show or late cancellation, any future appointments will not be held until I contact the office, at which time appointments will be scheduled based on availability and at the discretion of the treating provider.

For therapy clients: I acknowledge and authorize the below credit card to be charged ***$30*** if I do not show for an appointment or do not cancel before close of business on the day prior to my appointment.

For testing clients: I acknowledge and authorize the below credit card to be charged ***$100*** if I do not show for an appointment or do not cancel before close of business on the day prior to my appointment. This fee applies to all scheduled interactions with assessment clients, including but not limited to scheduled calls, in person appointments, and telehealth appointments, regardless of scheduled length of appointment.

In the event that you do not show up to an appointment, and do not call to cancel, you may receive a call from the office within one week of your missed appointment to see if you would like to reschedule or terminate services. If we do not get ahold of you, we may send a letter via your home address to indicate your case has been terminated. These processes are subject to change based on your treating provider's discretion. You may call to reinitiate services should you desire, based on the availability and discretion of the treating provider.

In the event that you do not fill out the below credit/debit card information, by signing this agreement you are acknowledging and agreeing that the fee will be paid over the phone or in person before being able to schedule or attending an upcoming appointment.

Name on Card: _____

Credit Card on File: _____

Expiration Date: _____ CVV code: _____

Billing Address: _____

I hereby agree to the Cancellation, No-Show, and Termination policy. I am responsible for keeping my credit card information up to date and agree to inform Smith Psychological Services of any changes as soon as possible. Smith Psychology Services will also have full discretion for unpaid accounts and will take necessary actions to collect any unpaid balances.

_____ _____

Patient/Responsible Party Date

_____ _____

Witness – Smith Psychological Services Date