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
Fax: 307-632-9697

Notice of No-Show & Late Cancellation Policy

We value your time and are committed to providing quality care. To help ensure availability for all clients and support consistent scheduling, we have implemented the following No-Show and Late Cancellation Policy. Please review the information below carefully. You will be asked to acknowledge this policy as part of your general consent to treatment.

Cancellation Requirements

If you need to cancel or reschedule an appointment, we ask that you notify our office **no later than 5:00 PM the business day prior** to your scheduled appointment. You may cancel by calling our office at **307-632-7771**. If no one is available to take your call, please leave a voicemail—**voicemail timestamps will be used to verify the time of your cancellation.**

Missed Appointment Policy

If you miss an appointment (including late cancellations), the following will apply:

- **Your future appointments will not be held** until you contact the office to reschedule.
- Appointments will be rescheduled **based on provider availability** and at the **discretion of the treating provider**.

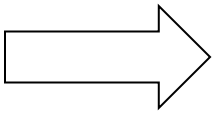
Fee Structure

Fees for no-shows or late cancellations will be charged based on the type of service scheduled:

- **Therapy Clients:**
  A $30 fee will be charged to the **credit/debit card on file**. If no card is on file, an invoice will be sent.
- **Testing/Assessment Clients:**
  A $100 fee will be charged to the **credit/debit card on file**. This applies to **all scheduled interactions**, including phone consultations, in-person appointments, and telehealth sessions, regardless of appointment length. If no card is on file, an invoice will be sent.

Re-engagement After a Missed Appointment

If you do not show up for an appointment and do not call to cancel, our office may attempt to contact you within one week to determine if you wish to continue services. If we are unable to reach you, a letter may be mailed to your home address notifying you of service termination. These procedures may vary depending on your provider's discretion.



Should you wish to resume services in the future, you may contact the office to request re-initiation, which will be considered based on scheduling availability and provider discretion.

Payment Without a Card on File

If you choose not to keep a credit/debit card on file, please be aware that payment for **any no-show or late cancellation fee may be required to be paid in full by phone or in person prior to rescheduling or attending any future appointments**.

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Voluntary Credit Card on File Authorization & Consent

Patient Name: _____

DOB: _____

To simplify payments, clients have the option to keep a credit or debit card securely on file with Smith Psychological Services. This is a **voluntary authorization,** and you may choose to opt in or out at any time.

Credit Card Information (Optional)

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Number: _____

Expiration Date (MM/YY): _____

Security Code (CVV): _____

I **voluntarily authorize** Smith Psychological Services to securely store the above card and charge it for the following:

☐ _____ Insurance CoPays at the time of service
initial

☐ _____ Late cancellation or missed appointment fees in accordance with practice policy
initial

I understand that :

- This consent is optional and can be withdrawn in writing at any time.
- I may use another method of payment at any time, if preferred.
- My information will be stored securely in compliance with HIPAA and PCI regulations.
- I will receive a receipt upon request for any charges made.

Signature of Cardholder: _____ **Date**: _____

☐ *I decline to store a card on file at this time* _____
initial