 [admin@ctpsychnow.com](mailto:admin@ctpsychnow.com)

(860) 893-5628

**No Show, Late Cancellation, and Consent**

Please initial the following agreements:

\_\_\_\_\_\_\_ Except in the case of a documented emergency, I understand that I will be charged a LATE CANCELLATION fee of $60 if I fail to give at least 24 hour notice prior to cancelling my appointment. I understand that I will be charged a NO SHOW fee of $60 if I fail to show for my appointment.

\_\_\_\_\_\_\_ I understand that I am responsible for knowing my copayment amount and yearly deductible amount. My copayment amount per session is \_\_\_\_\_\_\_, and I agree to pay this amount at each appointment. I agree to pay sessions fees according to my insurance deductible.

\_\_\_\_\_\_\_ I understand that each therapy session will last approximately 55 minutes. I understand that if I am late to the appointment, the session will still have to end at the allotted time and I am still responsible for my full session payment.

I give CT Psych Now permission to contact me for scheduling and coordinating care via (please check all that apply):

* Email (Must check in order to receive appointment reminders via email)
* Text message
* Voice message

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED AND READ THE

“NOTICE OF PRIVACY PRACTICES” and “HIPPA AND INFORMED CONSENT” AND AGREE TO ITS TERMS.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (if 15 and older) Date

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Parent/Guardian Signature Date