

HELPING HANDS, INC.
ATTENDANCE/CANCELLATION POLICY – *Effective February 2023*

****For the purpose of our attendance/cancellation policy, any appointment NOT attended is considered a NO SHOW***

- **All cancellations must be made at least 24 hours prior to your appointment, to avoid a NO SHOW fee.** For each appointment, a full hour of staff time and treatment space are reserved for your child, therefore proper notice allows us adequate time to potentially fill that time slot with another patient. Please call to cancel any appointment—we do not accept emails to our website to cancel an appointment. Our therapists are not responsible for communicating their clients' cancellations, scheduling conflicts, and vacation info to the front office. _____ *Initial*
- **If an appointment is NOT cancelled within 24-hours, for ANY reason, the patients account will automatically be assessed a \$50.00 NO SHOW fee. If parents/guardians reschedule their child's appointment, then the fee will be reduced to \$25.00** _____ *Initial*
- **Appointments that are not attended by the patient with no notification to the front office are subject to a \$50.00 NO SHOW fee. WE DO NOT WAIVE THIS FEE** _____ *Initial*
- **All NO SHOW fees will be billed directly to you. These fees must be paid before or at the time of your child's next appointment or the child will NOT be seen.** Neither your insurance company nor your flexible spending account will cover these fees. _____ *Initial*
- **Please be aware that we will do everything possible to match the therapist and family schedule, however a reschedule may occur with any therapist in our office at any available times.** For example, if your regular appointment is at 5PM, there is NO guarantee that when rescheduling you will be able to have the same time and therapist. _____ *Initial*
- **Our office will make every effort to provide therapy to your child in circumstances where clients are late checking in.** If you arrive late to your child's appointment, the session will conclude at its regularly scheduled end time; however, if you arrive more than 15 minutes late, your child will not be seen and you will be required to reschedule the appointment or pay the NO SHOW fee of \$50.00. _____ *Initial*
- **Our office reserves the right to remove from the schedule a client who is not regularly attending therapy or a client who continuously arrives late.**
 - **Two "NO SHOWS" of your child's regularly scheduled appointment (within the duration of your treatment plan) that are not rescheduled will result in your child being removed from the schedule effective immediately.** If there are extenuating circumstances preventing you from bringing your child to their appointment, please contact the front office immediately to discuss and avoid removal from the schedule. _____ *Initial*
- **We require that an adult be ON SITE during the full length of their child's therapy session. If you are not able to remain on the premises, we require you to reschedule the appointment.** _____ *Initial*

By signing below, I acknowledge receipt of this attendance & cancellation policy and agree to the terms stipulated above.

Signature of Parent/Guardian

Date

Client Name: _____ Date of Birth: _____