Dawn Womack, MSW, LCSW, BACS
Child and Adolescent Counseling, LLC

24 Hour Cancellation Policy/Credit Card on File

Phone (225) 647-5500 Fax (225) 208-1366
Email: Haley@dawnwomack.com

Please email or fax this form using the contact information above.

Client Name: _____ DOB: _____

We realize that clients may need to cancel or change their appointments from time to time. If you must do so, please call our office and leave a message or email us using the contact information above at least 24 hours before your scheduled appointment time. If you fail to cancel a scheduled appointment at least 24 hours in advance, we cannot use this time for another client and you will be responsible for the full cost of the appointment fee ($100). Insurance will not cover this cost.

- If you do not show up for your scheduled appointment and have not notified us at least 24 hours in advance, you will be required to pay the full cost of the fee for the session. All future appointments will be cancelled and will need to be rescheduled once payment has been made.

- If you are more than 20 minutes late for a scheduled appointment without calling and leaving a message or emailing us to let us know using the contact information above, we may move up the next client's appointment or may leave for the day. We will consider that the appointment has been missed.

- If your child is sick the morning of the appointment, you may call before 8:00am and leave a voice message or send an email using the contact information above advising that your child is sick and the 24 hour notice will be waived pending verification of school absence. Other exceptions to this policy are only given for emergencies and at our discretion.

Cancellation Policy – Please select one option below:

I understand that charges for missed appointments are not covered by any insurance and are my sole responsibility. By checking either box and signing below, I acknowledge that I have read and agree to comply with the 24 Hour Cancellation Policy.

☐ Yes I will provide credit/debit card information to guarantee payment and understand that my card will be billed in the case of non-compliance with the 24 Hour Cancellation Policy. I authorize Dawn Lundin Womack to charge this credit/debit card for any missed appointment fee.

☐ No, I choose not to provide credit/debit card information to guarantee payment and understand that by not providing a debit/credit card to guarantee payment, I may not be eligible for high demand evening appointments, and that I will still be responsible for any missed appointment fee which will be due before future appointments will be scheduled.

Check One: ☐Visa ☐Mastercard ☐Discover ☐Amex Billing Zip code:_____

Card Holder Name:_____ Expiration:____/____ 3 Digit Code: _____

Card #:_____ Email address for receipts: _____

Signature:_____ Date:_____
Computer signatures are not acceptable

Credit Card on File for Therapy Session Payments:

We prefer to handle credit or debit card payments by billing a card on file. If you prefer to pay at the time of the appointment, please pay by cash or check. If you do not have a credit or debit card on file and do not pay by cash or check at the time of the appointment, you will receive a phone call from our office to make a payment over the phone.

☐ I AGREE to keep a credit/debit card on file to pay for therapy sessions. I hereby authorize Dawn Womack to charge this credit/debit card for therapy sessions.

Check One: ☐**Visa** ☐**Mastercard** ☐**Discover** ☐**Amex** **Billing Zipcode:**_____

Card Holder Name:_____ **Expiration:**____/____ **3 Digit Code:** _____

Card #:_____ **Email address for receipts:** _____

Signature:_____ **Date:**_____

Computer signatures are not acceptable