The Center for Psychological Counseling Services, Inc.
5124 Hollywood Boulevard
Hollywood, FL 33021
Tel: (954)894-1174 & Fax: (954)965-4597

CANCELLATION/MISSED APPOINTMENT POLICY

Patient Name: _____ Date: _____

Your appointment time has been set aside for you. This time is unavailable to other patients. Therefore, we require at least 24 hours advance notice if you need to cancel your appointment. For all missed appointments with less than 24 hour notice, you will be charged a **$65.00 cancellation fee**.

Appointment reminder calls are a courtesy. Should you not receive a reminder telephone call, it is still your responsibility to remember your appointment.

I _____have read and understand the cancellation/missed appointment policy.

_____
Patient Signature

If patient is a minor, please provide parent or guardian information.

Name: _____ Relationship: _____

_____
Parent/Guardian signature

Rev 03/16