DALLAS COUNSELING & TREATMENT CENTER

CANCELLATION FEE WAIVER REQUEST

POLICIES:

CANCELLATION POLICY
Cancellations must be made at least 24 hours prior to your scheduled appointment time. We accept cancellations by phone call, text, email, or through response to electronic reminders. A cancellation fee equal to 100% of the scheduled service will be applied for all cancellations made with less than 24 hours' notice. Insurers do not pay for missed sessions, therefore you will be held responsible for the full amount of each scheduled service without insurance benefits applied. We require a credit card number be given so that appropriate fees may be charged if a late cancellation does occur. If you are unsure of the full cost of scheduled services, please contact us to inquire.

LATE ARRIVALS
We cannot guarantee you will receive the services you scheduled if you arrive more than 15 minutes late. If you think you may be late for your appointment, please call to inform us and we will do our best to accommodate you. However, if we are unable to make accommodations, you will still be charged the full amount for the scheduled services without insurance benefits applied. This is because insurers will not cover the cost for a session if you are not present the entire time.

NO-SHOW/NO-CALL POLICY
If you do not show up for your scheduled appointment, and you do not cancel in accordance with our Cancellation Policy, you will be charged the full amount for each scheduled service you missed. Clients who no-show on more than one intake session will be required to pay in advance before scheduling any future appointment.

HOW TO SUBMIT A CANCELLATION FEE WAIVER REQUEST
1. Complete the following information.
2. Email the completed form and any supporting documentation to clientsupport@dallasctc.com by 10 pm on the day of a missed appointment.
3. Your request is reviewed and a decision emailed to you.

COMPLETED FORMS MUST BE RECEIVED BY CLIENTSUPPORT@DALLASCTC.COM NO LATER THAN 10 PM ON THE DAY OF A MISSED APPOINTMENT.

CLIENT INFORMATION:

NAME:

DATE OF BIRTH:

PARENT/LEGAL GUARDIAN: (IF CLIENT IS UNDER 18)

APPOINTMENT CANCELLATION INFORMATION:

DATE & TIME OF SCHEDULED APPOINTMENT:

DATE & TIME OF CANCELLATION:

THERAPIST:

PLEASE BRIEFLY DESCRIBE THE REASON FOR REQUESTING A CANCELLATION FEE WAIVER: