Thomas B. Allen II, Ph.D., Director
Brian D. Fay, LCSW
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Please read and sign the front and back of this form**

No Show/Late Cancellation Policy

The Clinical Staff at *PATHWAYS* requests that you give at least 24 hours notice if you will not be able to make a scheduled appointment. If a Monday appointment needs to be cancelled a call must be received on Friday by 3pm. With sufficient notice we can usually offer your appointment time to another patient and fill that slot.

Please be aware that if we **do not receive at least 24 hours notice** you will be charged a fee of **$75.00**. Due to a variety of extenuating reasons; which may include but are not limited to: illness and car trouble, and in order to be fair to all patients, there can be no exceptions to this policy. We also understand that repeated no shows may indicate that someone is not yet ready to commit to treatment at this time. This should be discussed with your therapist so that appropriate planning can take place.

By signing below, I hereby understand and agree to comply with the above no show/late cancellation policy.

_______________________________ ___________
Signature of Patient/Guardian Date

_____________________________ ___________
Signature of Witness Date

251 Westbrook Rd., Essex, CT 06426 Phone: 860-767-1277 FAX: 860-767-7712
314 Flanders Rd., Suite 2B, East Lyme, CT FAX:860-691-1546
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Acknowledgement of HIPAA Policy

I , ______________________________________ acknowledge that *PATHWAYS*
(*Print First and Last Name)*

Center For Learning & Behavioral Health, LLC "Notice of Policies and Practices to Protect the Privacy of Your Health Information" has been made available to me. I am aware that I may obtain a copy of the policies at any time.

____ ______________

Signature of Patient (16 yrs of age and older) Date

____ ______________

Signature of Parent/Guardian Date

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