Thomas B. Allen II, Ph.D.
Suzanne D. Pascoe, LPC
Susan Scott, LMFT
Tori Piraino, LCSW
Mari Jo MacInnis, LMFT
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Judith Mohr, LMSW

Please read and sign the front and back of this form

No Show Policy and Late Cancellation Policy

$75.00

24 hours notice is required for all appointment changes.

You will be charged $75.00 for missed appointments and late cancellations.

Monday appointments should be rescheduled no later than 3 p.m. on Friday.

We also understand that repeated no shows or cancellations 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.

Please contact your Therapist directly regarding cancellations or appointment changes

By signing below, I hereby understand and agree to comply with the above

No Show Policy and Late Cancellation Policy.

____________________________________ __________
Signature of Patient / Parent / Guardian 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
2418 Boston Post Rd., Guilford, CT 06437 FAX: 203-689-5096
152 Broad St., Guilford, CT 06437
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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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