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Loren B. Sterman, LCSW
Tracy A. Shiring, M.S. Ed
Lisa N. Backus, Ph.D.
Sarah A. Hallwood, LCSW
Rolando Martinez, LCSW
Margaret R. Watson, Psy.D.
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
www.pathwaysct.com



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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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