STERLING CARE
PSYCHIATRIC GROUP, INC.

LATE CANCELLATION & MISSED APPOINTMENT POLICY

I understand that my appointment time is reserved specifically for me. Cancellation notice must be received at least *48 business hours* prior to the appointment. We charge the full price for late cancellation or no show appointments, unless there are special circumstances beyond your control. We will not offer to reschedule late cancellations or no shows for the initial evaluation session.

NAME: _____ SIGNATURE: _____DATE: _____

CREDIT CARD AUTHORIZATION

I hereby authorize Sterling Care Psychiatric Group, Inc. to charge my credit card for the treatment provided to myself/my spouse/my child, amounting to the co-pay charge, the full charge of each session, or the late cancellation/no-show charge.

Initial: _____ Please charge each visit to my credit card

Initial: _____ Please charge my credit card on file for charges over 30 days past due

Credit Card #: _____ Exp. Date: _____

Name On Card: _____ Security Code: _____

Billing Address: _____ Zip: _____

NAME: _____ SIGNATURE: _____ DATE: _____