Tania Davidson, Psy.D. A Psychological Corporation

NO-SHOW AND CANCELLATION POLICY

This is my declaration of agreement regarding missed or cancelled appointments. I understand and agree to the following:

1. It is my responsibility to notify Dr. Davidson at (805) 320-5256 or the office phone number at least 24-hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.
2. I agree that I will be billed the session fee in the event that I do not show for an appointment or fail to cancel at least 24-hours prior to the scheduled appointment.
3. If I violate this policy, I agree to be charged for the session automatically by credit card (complete below).
4. An emergency that is unforeseen (illness, accident, for example) is not subject to this policy.

Patient Signature : ____

Date: ____

Type of Card: VISA ❒ MasterCard ❒ Exp. Date: _____/______

Card Number: ________________-_________________-_________________-________________

Verification/Security Code (3 digit code on back of card by signature line):________________

Billing Address:____

City:_________________________ State: ______________________ Zip:_________________