Anchor & Balance Restorative Services, LLC
Sarah B. Michalowski, DSW, LCSW
Telehealth
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551-333-9679 (google voice)

Cancellation Policy and Authorization for Credit Card Use

Your therapy appointment is reserved for you. Therefore, you are responsible for attending each appointment and agree to adhere to the following policy. If you cannot keep the scheduled appointment, you must notify me to cancel or reschedule the appointment within 24 hours of the scheduled appointment time. *Unless there is an emergency, appointments cancelled with less than 24 hours notice will incur a $75 cancellation fee.* "Emergencies" are considered events beyond your control such as snowstorms, car accidents, funerals, hospitalizations, or illnesses of the degree which keep you out of work.

This policy applies to an appointment you did not cancel because you have decided not to continue counseling, an appointment you "forget" or an appointment which conflicts with another one you have made. It also applies if you choose to do something that is important to you rather than coming to your counseling appointment that day.

Charges for late cancellations or missed appointments are not billable to your insurance company. Therefore, you will not be able to submit it to your out-of-network benefits and I cannot submit it to your insurance as a billed session.

If you cancel or rescheduled more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time. If at some point you decide not to continue in counseling with me, please call me and leave a message, especially if you have appointments scheduled. This allows me to release that time on my calendar.

If you have any questions about this policy, please let me know as soon as possible.

Date: ______________________

Client/Legal Guardian Signature: ___________________________________

Printed Name: ____

If you choose to not use a credit card please set up the ZELLE App with your bank in order to submit payment directly to me. Please provide the following credit card information, which will be charge **only** in the event that a 24-hour notice is not provided.

Name on card: ____

Credit card type: Visa______ Mastercard_____ Discover_____ American Express_____

Credit card number: _________________________________ Expiration date: ______________

Security code number: ____________________ Zip code: ___________________________

I authorize Sarah B. Michalowski, DSW, LCSW of Anchor & Balance Restorative Services, LLC to charge the amount listed above to the credit card provided. I agree to pay for this purchase as in agreement with the credit card company.

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Cardholder Signature Date

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Print Name