p 410.863.7213 f 410.987.3154 www.pdgrehab.com
1110 Benfield Blvd, Suite B, Millersville, MD 21108

Cancellation / Missed Appointment Policy

Keeping your scheduled appointments is a vital part of the recovery and treatment process. When you make an appointment at PDG Therapeutics, you are asking a professional to hold a specific block of time for you. To efficiently serve you and others, PDG Therapeutics has instituted a 24-hour notification policy for cancelling an appointment. Emergency cancellations are assessed by the clinician and the clinical director, and fees may be waived when appropriate. If you must cancel a scheduled appointment, please do so at least 24 hours in advance. Failure to give the proper 24-hour notice will result in billing you directly for the missed appointment. Your insurance cannot be billed for services that are not rendered.

You will be billed $75.00 for the missed appointment with the credit card on file when an appointment is cancelled within 24 hours or you fail to attend a scheduled appointment without notification.

To cancel any appointment, please call (410) 863-7213. **You will be removed from your assigned clinician's schedule and will not be permitted to schedule another appointment unless your fee is paid.** Failure to pay for your missed appointments/cancellations within **15 days** can result in your invoice being turned over to a collection agency and you will be responsible for any fees that our collection agency charges, in addition to your original fee.

I agree to the terms of PDG Therapeutics' Cancellation / Missed Appointment Policy:

I hereby give my permission and consent to receive treatment from PDG Therapeutics. I understand that this encompasses the intake and diagnostic evaluation process, as well as any therapies and/or referrals which may be recommended.

I acknowledge that the "Client's Rights" and "Grievance Procedure" statements have been provided to me. I have had an opportunity to review it and to ask any question which I may have about my rights as a client of PDG Therapeutics. "Client's Rights" and "Grievance Procedure" are posted on our website at www.pdgrehab.com, as well as in our lobby, and can be accessed or printed at any time.

I understand that all my treatment at PDG Therapeutics is voluntary, and that I may cease treatment at any time by informing my therapist and/or the office staff.

I understand that my clinical records and any verbal or written communications between myself, my parent (if applicable), or any authorized representative are strictly confidential. Further, no material or information will be disclosed to another party without my express written consent and/or that of a legally authorized representative. This excludes circumstances when there is a clear and imminent danger to myself or to others, or when disclosure is state-mandated (reported sexual abuse, physical abuse or neglect as a child or suspected current child abuse).

I understand and give my informed consent to PDG Therapeutics staff and or clinicians to contact police, emergency contacts and or emergency services if there is a medical emergency.

I hereby request PDG Therapeutics and its qualified members to call for other related support services as deemed necessary and appropriate for my emotional and physical safety.

This informed Consent has been explained to me, and I have been offered a copy for my records.

X _____
Printed Name

X_____
Client Signature **Date**

_____
Therapist/Intake Worker **Date**