



## CANCELLATION POLICY of Alliance Child & Family Solutions (“ACFS”)

1. **Purpose of Notice:** To see our clients as efficiently as possible and avoid wait time for you, we do not overbook time slots for Treatment or Services. When an appointment is made, it prevents other Clients from receiving services with one of our Service Providers during that time. Please be advised of the following fees AND scheduling policies.
2. **Types of Changes to Scheduled Appointments:**
  - a. **No Show:** A “no show” is missing a scheduled appointment. – **FEE WILL BE ASSESSED**
  - b. **Late Cancellation:** A “late cancellation” is any cancellation less than 24 hours from your scheduled appointment time. – **FEE WILL BE ASSESSED**
  - c. **Cancellation:** Regular cancellations are appointments that are scheduled but are changed with at least 24 hours’ notice or more in advance. This is still considered an unplanned change, but **NO FEE assessed**.
3. **Amount of Fee:** The cash pay price of your Service Provider will be assessed for each no show, or late cancellations with less than 24 hours’ notice given prior to cancellation request.
  - a. **FEE OF \$125.00** for Service Providers with Full Clinical License – LCSW, LPC, LMFT
  - b. **FEE OF \$75.00** for Midlevel Service Providers – LMSW, LPC- Associate/Intern, LMFT-Associate, QMHP
  - c. **FEE OF \$25.00** for Graduate Practicum Student
  - d. NO FEE for Bachelors Practicum StudentsPlease understand that insurance companies consider this charge to be entirely the client’s responsibility and you will not be contacted by our Billing Department prior to your card being charged for missing or late cancellation of a scheduled appointment.
4. **Exceptions:** We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. **These situations will be considered on a case by case basis.**
  - a. You should call the office as soon as you become aware that you will miss an appointment, even if it is less than 24 hours before your appointment. **If you call and someone is not available to take your call, you must still leave a detailed message or e-mail to possibly avoid financial penalties.**
  - b. While we do our best to send reminders ahead of the appointment, **it is the Client’s responsibility to be aware of any appointments scheduled with the Service Provide.** Client may still be assessed financial penalties for a missed session even if Client did not receive a reminder call, text, or email in advance.
5. **Recurring Appointment & Cancellations:** Our Service Providers and Staff work in conjunction to provide you with a convenient time for you to attend your appointments on an ongoing basis. For this reason, multiple cancellations, even with advanced notice, can leave our therapists with open spots yet without allowing additional clients to be seen.
  - a. **Two Unplanned Changes:** A combination of two no shows, cancellations (*even with sufficient notice*), or late cancellations within a short period of time can lead to your scheduled spot being provided to another client, especially if during the hours of 3 – 8pm or on a weekend, as these times are in high demand.
  - b. **Three Unplanned Changes:** This can lead to being referred to another practice at the discretion of the Service Provider or Staff depending on the circumstances.
6. **Where to Cancel:** Best practice is to cancel via OnPatient Message or by phone directly with your Service Provider by dialing **817-851-2042** then entering the Service Provider’s extension when you hear the voice prompt.
  - a. If you do not know your Therapist’s extension, you can enter **Extension 0 (Zero)** to be connected with or leave a message for Customer Service.
  - b. You can also provide written cancellation via e-mail to [referrals@acfstexas.com](mailto:referrals@acfstexas.com).

**By my signature below, I am indicating that I have read and understand all of the above, have had an opportunity to ask questions about this information, and I consent to this Policy as part of my Services and Treatment.**

**This Policy is signed, submitted, and effective as of today's date, \_\_\_\_\_**

\_\_\_\_\_  
**Name of Client**

\_\_\_\_\_  
**Name of Legal Guardian (if applicable)**

\_\_\_\_\_  
**Signature (Client/Legal Guardian)**

\*NOTE: The signatures on this form are considered valid and true regardless of whether hand signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, or another approved electronic venue, and that I am consenting to all of the above statements with my electronic signature, even if the signature does not appear on the exact lines above.