DONNA GOLD, LCSW
Psychotherapist Specializing in Trauma Survivors

Courage • Compassion • Connection

CANCELLATION POLICY AGREEMENT

I understand I am responsible for full payment due at the beginning of each session, and I should contact my insurance company to gain a better understanding of my out of pocket expenses for services provided by an "out of network" provider. **I understand that I am responsible for all charges, regardless of insurance coverage, and for missed appointments or cancellations with less then 24 hours notice.** I understand I am responsible for seeking reimbursement through my insurance if I have insurance. I authorize this office to release any information necessary to expedite insurance claims if applicable. A copy of this signature is valid as the original.

Your credit card will not be billed without your permission at the beginning of the session unless you fail to provide 24 hours advanced notice, at which time you will be notified that you are being charged the full session fee for the missed session.

Name as it appears on card: _____ Card Type (Visa, MC, AE): _____

Account Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Expiratition Date: _____ /_____

CVV Code (on back of card) ___ ___ ___

Cardholder Signature: _____ Date: _____

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