

Tania Davidson, Psy.D. PSY16510
Licensed Clinical Psychologist



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 (760) 729-5900 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 insurance contracted rate or the regular fee if I pay out of pocket in the event that I miss 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).

Patient: _____

Clinician: _____

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: _____