Late Cancellation and No-Show Policy

Effective Date: January 20, 2025

At Doria Therapeutic Group, PLLC, we are committed to providing timely, high-quality mental health care. Regular attendance is essential to effective treatment and ensures continuity in the therapeutic process. Missed or late-canceled appointments not only disrupt care but also limit availability for other patients in need. To maintain fairness and respect for both our patients and clinicians, we have established the following Late Cancellation and No-Show Policy.

Policy Details

1. Cancellation Notice Requirement
Appointments must be canceled or rescheduled at least **24 hours in advance** of the scheduled session time.

2. Late Cancellation / No-Show Fee

- Appointments canceled with less than 24 hours' notice, or missed without notice, will incur a **$200 fee**, charged to the card on file.
- This fee is **not covered by insurance** and is the patient's full financial responsibility.

3. Automatic Charge Authorization
By signing our Practice Policy, patients authorize Doria Therapeutic Group, PLLC to charge the card on file for applicable late cancellation or no-show fees in accordance with this policy.

4. Dispute Waiver Agreement
By signing, the patient agrees not to dispute any valid charge made under this policy. Attempting to dispute properly authorized charges may result in:

- Suspension or termination of future appointments and care
- Referral to collections and potential legal action

(914) 246-4100 (888) 301-8044 office@doriatherapeuticgroup.com www.doriatherapeuticgroup.com 173 Huguenot Street, Suite 200 New Rochelle, NY 10801

Legal Acknowledgment

This policy is an extension of your financial agreement with Doria Therapeutic Group, PLLC. In accordance with the federal **E-SIGN Act** and applicable state contract laws, your electronic signature and agreement to these terms are legally binding.

By signing below, you confirm that:

- You were provided with this policy prior to beginning services.
- You understand and accept the financial responsibility for missed appointments or late cancellations.
- You authorize all related charges and waive your right to dispute them with your financial institution, except in cases of documented fraud or billing error.

Patient Agreement

I, the undersigned, acknowledge that I have read, understood, and agree to comply with the Late Cancellation and No-Show Policy outlined above. I accept full financial responsibility for any fees incurred as a result of missed appointments or late cancellations, as described in this agreement.

Signature: _____

Patient Name: _____

Date: _____

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