Tania Davidson, PhD, Registered 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 at 022 534 4533 or email drtaniadavidson@hushmail.com 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 regular fee 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:_____ Region: _____

Code:_____