

# THE COMPASS PROJECT THERAPY

## No Show, Late Cancellation and Payment Policy

1. I understand that the therapy session will last **50 minutes** **FOR WHICH THE RATE WILL BE \$120.00**
2. I understand that I will be charged a LATE CANCELLATION fee of **\$120.00** if I fail to give at least 24 hour notice prior to cancelling my appointment.
3. I understand that I will be charged a NO-SHOW fee of **\$120.00** if I fail to show for my appointment.
4. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

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Signature of Responsible Party

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Date