The Solution Counseling Center
2270 Drew Street, Suite C
Clearwater, FL 33765

**Statement of Responsibility for Payment**
**<u>During No Shows or Late Cancellations</u>**

I understand and agree to give 24 hours notice if I am unable to keep any appointment. I understand that if I fail to show for a scheduled appointment, or if I do not cancel with 24 hours notice, I will be charged my co pay or a fee of $35.00 and will be responsible for payment of that fee.

________________________________________
Signature

________________________________________
Date

## Message Authorization

There may be instances when your therapist needs to change and/ or confirm your appointments via email or text. To protect your confidentiality, your permission is needed to correspond by email or text message. I give my therapist permission to contact me at the following:

Signature:____________________ Phone Number:____________

Email address:__________________________________________