

**Redding Counseling, LLC**  
**Lenore Pranzo, MA, LMFT, Cht, PhD**

**Appointment Cancellation and Financial Agreement**

**First name:**

**Last Name:**

Each meeting is another opportunity to help you confidentially take charge and start living the life that is important to you. It is understood that things come up and you may need to miss your appointment. If you need to reschedule or cancel any appointments, **24-hour notice** is required. Please understand that the time is set aside for you, and if you are unable to make it, there is a missed opportunity to meet with another valuable client. This policy is in place to give enough time to schedule another client in that time slot. If you fail to cancel without giving 24 hours prior to your appointment, a \$50 fee will be charged to the card below.

**I authorize the following card to be used for co-pays and fees incurred during the time I am a client with Redding Counseling, LLC.**

Card Number

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Expires

CVV

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Printed Name

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Signature

Date

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I understand that the office of Redding Counseling, LLC will attempt to bill my insurance, however, **if my insurance does not pay, for whatever reason, I am responsible for any remaining balance.** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency, I will call 911 or go to the nearest hospital.
- I will adhere to the cancellation guidelines above to the best of my ability.

Client Name (Please Print)

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Client/Guardian signature

Date

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