Locations
317 North Main Street and 1075 Tolland Turnpike
Manchester, CT 06042
860.643.2101 | www.ccgcinc.org

# Cancellation/Failed Appointment Policy Insurance Coverage

Regularly scheduled appointments are an important part of treatment and affect both the quality of care and the possibility of successful outcomes. Clinic staff will make every effort to provide regular appointments at a time convenient to you and your family. So that you will be aware of the clinic's policies about appointments, we are offering the following explanations:

**CANCELLED APPOINTMENTS**

A minimum of 24-hour notice is requested if you need to cancel your appointment. Cancellations should be phoned in to your therapist or the Clinic secretary.

**FAILED APPOINTMENTS**

If you do not call to cancel and do not come to your scheduled appointment, your therapist will be in touch with you regarding the missed appointment. Another appointment will be scheduled if you request it.

**TIME SLOTS**

Two canceled or failed appointments in a row may mean that your therapist will not be able to reserve your preferred appointment time for you. This is especially true when the time slot is in the late afternoon or evening, since there is much demand for these slots.

**TERMINATION OF TREATMENT**

Three cancelled and/or failed appointments within an eight-week period will result in termination of services, unless there are extenuating circumstances. You may feel free to re-apply for services at a later time.

**INSURANCE COVERAGE**

We do not guarantee coverage by your insurance for Clinic services. You are responsible for all services not covered by your insurance group. If your insurance has a set co-payment, you are responsible for paying this at the time services are rendered. If you have a change in insurance carriers, you are responsible for notifying the insurance billing department.

We hope that these policies will help everyone to have access to timely and effective treatment. Thank you for your cooperation.

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I have received and reviewed the above policy and am aware that my copayment is $______________, and is to be paid at the time services are rendered.

| ____________________________________ | __________________ | ________________________________ |
|---|---|---|
| Parent/Guardian Signature | Date | Child's Name |

Rev 09/02 Commercial Ins.