Journey of Life Psychological, Inc.
Denied Insurance Claims and Appointment
No Show/Late Cancel Acknowledgement

I authorize Journey of Life Psychological, Inc. to bill my insurance company (if applicable). I also acknowledge that I am financially responsible for any balance unpaid by my insurance company (minus applied payments and/or co-payments) and understand that Journey of Life Counseling will bill me for denied claims.

Client Signature: _____ **Date:** _____

Print Name of Client: _____

Therapist Initials: _____

I understand that Journey of Life Psychological, Inc. will bill me a $50 administrative fee for sessions in which I do not show or have not canceled within 24 hours of my scheduled appointment.

Client Signature: _____ **Date:** _____

Print Name of Client: _____

Therapist Initials: _____