**ALLISON D. OSBURN-CORCORAN, M.A., MFT**
**LICENSE NO. LMFT52602**
**LICENSED MARRIAGE AND FAMILY THERAPIST**
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# CANCELLATION OF APPOINTMENTS

I/ we understand that scheduling of an appointment involves the reservation of time specifically for me/ us. I/ we further understand that a minimum of **24 hours (1 day) notice** is required for rescheduling or canceling my/ our appointment. I/ we understand and agree that **my full fee** will be charged for sessions missed without such notification.

Dated: _____, 20___

_____
Client Name (please print)

_____
Signature of Client ( if Client is 12 or older)

_____
Signature of Representative (and relationship to minor)

_____
Signature of Representative (and relationship to minor)