Susan V. Sims, LMHC, MCAP
3502 Henderson Blvd; Suite 205; Tampa, FL 33609

PATIENT ACKNOWLEDGEMENT FORM

Remembering the date and time of my scheduled appointments is my responsibility. If a reminder call is given, it is a courtesy only & does not negate my responsibility for my sessions.

If I need to cancel or reschedule my appointment, I agree to provide Susan Sims, LMHC, a minimum of **24 hour**s notice excluding weekends/holidays.

I understand that I will be billed $75.00 for any appointment that I fail to cancel or reschedule without **24 hours** notice excluding weekends/holidays.

I agree to leave a working credit card on file, & I give permission to charge the card in the event of a late cancelation or no-show for an appointment.

VISA/ MC_____

EXPIRATION DATE _____ /_____ SECURITY CODE: _____

BILLING ZIP CODE _____

If I am utilizing my medical insurance benefits, I understand that Susan Sims, LMHC, MCAP has a relationship with me, not my insurance company. She will bill my insurance promptly after services are rendered. At times, insurance companies will deny payments for various reasons. Whatever my insurance does not pay after 60 days, I will be billed for the outstanding balance. I understand that I have the right to question my insurance company's denial or policies regarding my mental health benefits. I further understand that Susan Sims, LMHC, MCAP will do her best to assist me in understanding my benefits.

My signature below and initials above indicate that I have read and understand, and I agree to comply with all the above.

_____ _____

Signature of Patient/Responsible Party Date