Find Your Balance Counseling Group, LLC
240 US Highway 206, Unit 20, Flanders, NJ 07836
findyourbalancecounseling.com

Contact Information Form

May we leave a message concerning clinical treatment…..

- On your answering machine or voicemail? **YES or NO**
- Office or Work Voicemail? **YES or NO**
- With another Person? **YES or NO**

May we text the following for upcoming appointments…..

- On a personal cell phone? **YES or NO**
- Office or work cell phone? **YES or NO**
- With another person? **YES or NO**

May we email the following concerning clinical treatment…..

- On a personal email? **YES or NO**
- On an office email? **YES or NO**
- To someone else's email? **YES or NO**

Please list the persons(s) with whom we can discuss your protected health information:

_____

_____

_____

_____

Cancellation Policy

In order to serve our clients better, we have instituted a cancellation policy. We require a **24 hour notice** for all cancellations. As a courtesy, reminder calls or text are made 2 days prior to your scheduled appointment. We ask that you provide us with the same courtesy. If an appointment is missed or cancelled without 24 hour notice there will be a **$50.00 cancellation fee** billed to the client. If a client is able to reschedule within the week, the may be waived. By signing below I am acknowledging that I have been notified of the cancellation policy.

Patient Name (printed): _____

Signature: _____ **Date:** _____

Relationship to Patient (if a minor): _____