**Present**

# Client Request for Services

**Tele-Mental Health Walk- In**

**Name**

**Address: Telephone Number:**

**Insurance provider: State: Insurance ID #: Group: Name of Insured Client: D.O.B: Email: Summary :**

[**Email to cameronancompany@gmail.com**](mailto:Emailtocameronancompany@gmail.com)

**Our Cancellation/No Show Policy**: Patient must call 24 hours prior to appointment to cancel and reschedule. You will be billed a $ 50.00 fee for missed appointments. You will receive a confirmation call 24-48 hours prior to your appointment. You will also get an email or text message reminder. Co- payments, deductibles and/or full payments are due prior to each visit.

**For questions, call (855) 652-7225 Ext 4 for Sandy**