Cancellation Policy

Please be advised that **24 HOURS** advance notice of a cancellation is necessary to avoid the cost of the scheduled appointment. If you fail to timely cancel a scheduled appointment, I cannot use this time for another patient, and you will be responsible for the entire cost of the missed appointment.

Thank you for your consideration regarding this important matter.

By signing your name, you acknowledge, understand and accept this cancellation policy.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

Marsha Tilles, PsyD, LCSW / Lic.# LCS24181 / 310.746-5366 / www.DrMarshaTilles.com