



**THE ROSE GARDEN FAMILY SUPPORT CENTRE
LEEDS/GRENVILLE/LANARK
SUPERVISED ACCESS PROGRAM**

CANCELLATION FEE AGREEMENT

I, _____, have been explained by the staff of The Rose Garden Family Support Centre the “Cancellation Fee Policy”.

I, _____, agree to comply with the following policy and understand that failure to comply with this policy will result in my file being suspended:

All visits or exchanges cancelled without 24 hours notice will be subject to:

If I **cancel** a scheduled access appointment, a fee of \$5.00 will be charged.

If I am a **No Show** for a scheduled access appointment, a fee of \$20.00 will be charged.

All cancelled visits will be rescheduled as per court order or what was originally agreed upon intake.

Cancellations without 24 hours notice will be accepted **only** for the following reasons:

- 1) Sudden illness or medical concerns, ex: head lice, scabies. - A doctor’s note or proof of medication with precise date may be requested at any time; therefore, (3) three cancellations in a period of 1 year will require proof for all cancellations due to illness.
- 2) Death in the immediate family
- 3) Severe weather conditions

Staff reserves the right to cancel a visit at its discretion upon my arrival at this Centre for any of the above reasons and no cancellation fee will be charged.

Failure to pay cancellation fees once they have been issued will result in a **first** letter to myself and my lawyer with a request that the bill be paid. If the bill remains unpaid after the first letter has been issued, both my lawyer and myself will receive a **second** letter notifying that my family’s file has been suspended until I comply with policy and my bill is **paid in full**.

APPLICANT’S SIGNATURE

DATE

THE ROSE GARDEN FAMILY SUPPORT CENTRE

DATE