Patient Name _____DOB_____

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELED APPOINTMENT

I understand and agree to the following:

1. It is my responsibility to notify Dr. Svetlana Libus at least 48 hours prior to the scheduled appointment if I am unable to keep the scheduled appointment. I can do it by leaving a voice mail at 310- 517-7977 or by emailing to doclib85@hotmail.com

2. I agree that I will be billed the contracted rate of in the event that I miss an appointment or fail to cancel 48 hours prior to the scheduled appointment.

_____

Patient

_____

Practitioner