**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* **48 hours prior to the scheduled appointment** if I am unable to keep the scheduled appointment. I can do it by leaving message at 310-517-7977 or by emailing doclib85@hotmail.com

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

_____

*Patient*

_____

*Practitioner*