



**Svetlana Libus, M.D.**

*Child, Adolescent and Adult Psychiatry  
Board Certified*

**1926 S Pacific Coast Hwy, Suite 229  
Redondo Beach, CA 90227**

**Phone: (310) 517-7977**

**Fax: (310) 316-7841**

**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*, phone number: 310 372 0990

48 hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.

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.

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*Patient*

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*Practitioner*