

**DECLARATION OF AGREEMENT REGARDING
MISSED OR CANCELLED APPOINTMENTS**

I understand and agree to the following:

1. It is my responsibility to notify my psychologist, Tanya Mesirow, Psy.D. at her office (phone number: 951-775-4057) 24 hours prior to a scheduled appointment time if I am unable to keep that meeting.

2. I agree that I will be billed the contracted rate of \$100.00 in the event that I miss an appointment or fail to cancel 24 hours prior to my scheduled appointment.

Patient's Name: _____

Patient's Signature: _____

Date: _____