

Mark A. Welch, D. O.
Board Certified in Psychiatry
Board Certified in Sleep Medicine

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELLED APPOINTMENTS

I understand and agree to the following:

1. It is my responsibility to notify Dr. Welch **24 hours** prior to the scheduled appointment if I am unable to keep the appointment.
2. I agree that I will be charged **\$75.00** in the event that I miss an appointment or fail to cancel **24 hours** prior to the scheduled appointment.
3. Refills are given at the time of the visit. If you cancel, no-show, or reschedule your appointment and need a refill on your medications before your next visit, there will be a **\$10.00 fee** paid to the office.
4. I understand and agree to pay a deposit of **\$100.00** for my initial appointment with Dr. Welch if I am paying cash or not using my health insurance

Date: _____

Signature: _____

Print Name: _____