PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

aspen

## DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELLED APPOINTMENTS

I understand and agree to the following:

1. It is my responsibility to notify Dr. Lee at least **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 at least **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. Lee if I am paying cash or not using my health insurance

Date:_____ Signature:_____

Print Name:_____

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