MIND OPENER
DECLARATION OF AGREEMENT REGARDING
MISSED OR CANCELLED APPOINTMENTS

As a patient of Dr. Richard A. Shulman, A Psychology Corporation, I understand and agree to the following:

1. It is my responsibility to notify:

   Name: Dr. Richard Shulman
   Phone Number: 949-215-4200

   24 hours prior to the scheduled appointment if I am unable to keep a scheduled appointment. If the appointment falls on the day after a holiday or weekend, I will call at least one business day prior to reschedule the appointment.

2. I agree that I will be billed the agreed upon rate of $150 per session in the event that I miss an appointment or fail to cancel in the time frame described above.

3. I understand that the practitioner cannot bill the insurance for missed appointments and that I am fully responsible for the agreed upon rate.

_____
Patient/ Parent Name (print & sign)

_____
Practitioner (print & sign)

_____
Date