16755 Von Karman
Suite 200
Irvine, CA 92606

phone 949-242-4555
fax 714-882-6038

Consultation Agreement

Name: ____

Address: ____

Home Phone: _____________________Cell:__________________

I agree to pay __________ per hour for consultation at the time of services. Payment is due at the time services are rendered. Our office accepts checks, credit cards and cash.

If you need to cancel an appointment, please do so 24 hours in advance by calling Dr. Rounzoin's personal voice-mail @ 714-794-2878 or e-mailing him at ccrouanzoin@gmail.com. Appointments not canceled 24 hours in advance are subject to the full consultation fee.

By signing below you are agreeing to the above fee arrangement and cancellation policy.

_______________________________________ ______________

Name Date