Appointment Cancellation Policy

*Required Fields

Office Cancellation Policy

Patient First Name:* _____

Patient Last Name:* _____

Patient Birth Date:* _____

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you, and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office 48 hours' notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $75.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment, and the $75.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know, and we will be glad to clarify any questions you have. We thank you for your patronage.

☐ I have read and understand the Appointment Cancellation Policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

☐ I have received this policy and agree with its contents.

Signature By Patient

Patient's Signature: *

Sign

By drawing in the box above, I understand and agree that this is a legal representation of my signature

Signature By Guardian

Name: _____

Relationship: _____

Legal Guardian's Signature:

Sign

By drawing in the box above, I understand and agree that this is a legal representation of my signature

Submit