



Cancellation and broken Appointment Policy

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting. We are a private dental office not a dental "clinic" the appointment time is reserved for you alone.

Policy Fees:

Hygiene Appointments: \$25

Doctor appointments: \$35

Definition of "Broken Appointment": A broken appointment is when you

*Cancel or reschedule an appointment with less than 24 hour notice

* Do not show up for the scheduled appointment

Cancellation or rescheduling of an appointment less than 48 hours and up to 24 hours may or may not be considered a broken appointment; it will be at our discretion.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our second goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your dental treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

Regular scheduled appointments:

Emergencies and unforeseen problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you. We expect that other patients who might be slightly inconvenienced by this will be understanding of the situation. At some point, they may need the same courtesy too!

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask one of our staff members.

By signing below I acknowledge that I have read and understood the above mentioned policy.

X _____
Patient signature (parent or Guardian if minor)

X _____
Patient name

Date _____