

APPOINTMENT POLICY

PATIENT NAME: _____

DOB _____

Initial all policies that have been read and understood

Appointment Policy

_____ Due to a high number of patients requiring dental care, certain appointment times might not be readily available. Because of this, **we enforce this appointment policy to ensure that all patients receive care as soon as possible.**

- **Patients who are 10 minutes late to an appointment may have to be rescheduled depending on the schedule that business day.**
- **If your appointment is cancelled or rescheduled without a 24-hour business day notice, you will be subject to a \$50 reservation fee. *I.E. If you have an appointment scheduled on Monday, you would need to inform us the Thursday prior.**
- **If you have 3 broken appointments within a year, you will be dismissed from the practice.**
- **Procedures and appointments 2 hours or longer may be subject to a pre-payment to schedule the appointment.**

Appointment Confirmation Policy

_____ **If we have not received confirmation within 24-hour business day notice, your appointment may need to be rescheduled.**

- To confirm your appointment, we will reach out to you via our automated system, phone call, text message, and/or email starting 7 days prior to.
- We will try to confirm your appointment no later than 48 business hours before your appointment.

I do hereby consent and acknowledge my agreement to the terms set forth in the Appointment Policy and any subsequent changes. I understand that this consent shall remain in force from this point forward.

PATIENT/GUARDIAN NAME _____

DATE _____

PATIENT/GUARDIAN SIGNATURE _____