PERSONAL DENTAL OFFICE

CANCELLATION AND MISSED APPOINTMENT POLICY

1. Cancellation/No Show Policy for Dental Appointment:

At Personal Dental Office, your dental health is important to us, which is why every time we book an appointment for you, we book off time in our Doctors, Hygienists and Dental Assistants schedule to serve your needs. We strive to be on time for your appointments, and ask that you give us the same courtesy.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

We ask you, our patient, to give us a **minimum of 48 hour advanced notice for cancellations or to change your appointment**. Please note, all Monday Appointments need to be changed by 1:OO PM on Friday, or cancellation Fee Will apply.

Office appointments which are cancelled with less than 48 hours notification will be charged the following fees:

- **Exam/Cleaning/Follow Up/Consultation - $75**
- **Basic Dental Treatment - $150**
- **Dental Surgery/Comprehensive Dental Treatment - $250**

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Please note that such fees will not be covered by your insurance.

2. Numerous NO SHOW Policy:

Patients who do not show up for their appointment without a call to cancel will be considered as NO SHOW. Patients who Two (2) or more NO SHOW in a 12 month period, will be required to prepay for all future dental appointments in advance. All cancellation fees will apply.

Our practice firmly believes that good doctor/patient relationship is based upon understanding and good communication. Questions regarding the Cancellation/Missed Appointment policy should be directed to our patient coordinators.

Please sign that you have read, understand and agree to this Cancellation/ Missed Appointment Policy

Patient Name: _____

Name of Person Signing (if Minor) _____

Patient/Patient Representative Signature: _____

Date: _____