SHOWTIME
Family Dental

Missed Appointment and Cancellation Policy

We're glad you have chosen us to provide your Dental care. If you miss your appointments, you compromise your care. We want to remind you of our office policies regarding missed appointments and cancellation fees.

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for basic and major reservations, we require a credit/debit card authorization form to be fully filled out and signed by card holder. If treatment appointment is missed or not cancelled with in 24hrs a *non-refundable* late cancellation or missed appointment fee will be charged of $25 or $50 respectively.

A missed appointment is when you fail to show up for an appointment without a phone call, voice message, email or cancel without prior notification. We strive to be on time for your scheduled appointment and ask that you give us the same courtesy to notify us when you are unable to keep your appointment. We have outlined our missed appointment policies below.

Office Visits

We require a ***24 hour notice*** for all office visits otherwise a $25-$50 missed appointment or cancellation fee will be charged.

1st missed appointment: We will call and offer to reschedule your appointment. You will be charged a missed appointment fee of $25-$50.

2nd missed rescheduled appointment: You will receive written notification of your missed appointment and be charged a fee of $25-$50.

3rd missed rescheduled appointment: You will be charged an additional missed appointment fee of $25-$50. This may also result in a discharge from the practice.

NOTE: (Missed appointment and late cancellation fees will be charged to the credit or debit card listed as authorized. Please fill out attached Credit/Debit card authorization consent in order to reserve your dental treatment appointment. In the event the card is not active we reserve the right to not schedule you until fees are paid. *If payment has been collected for treatment the amount of the fee(s) will be deducted from the credit.* By signing below you agree you fully understand our policies.)

_____ _____

Patient/Card Holder Signature Date

_____

Printed Patient Name