Cancellation, Missed Appointment Policy
48 Hour Notice

In our continuing efforts to provide quality dental services in a timely and affordable manner, we are finding it necessary to implement a broken appointment policy. By instituting this policy we will avoid overbooking our schedule to accommodate the amount of patients who fail or cancel their appointments at the last minute. This policy should reduce long wait times in the office.

Confirming appointments is done as a courtesy to our patients and we will try to make every effort to contact each patient the day before a scheduled appointment.

An appointment is considered broken for one or more of the following reasons:
1. Failure to show up for a scheduled appointment
2. Cancelling an appointment without giving ***at least 48 business hours*** notice
3. Showing up more that 15 minutes late for an appointment

Patients who show a pattern of being 5-10 minutes late more than twice may have their appointment considered broken. Patients who show a pattern of broken appointments may be required to pay a refundable scheduling deposit for future appointments.

The broken appointment fee is $75 for routine visits and $100 for scheduled treatment appointments. Some insurances have their own broken appointment fees (which are set by the insurance). Broken Appointment fees must be paid before we will re-schedule any appointments.

By signing this agreement I understand the policy as defined above and agree to abide by it.

Patient Signature_____Date:_____
(If patient is a minor, guardian signature)

Your Signature is necessary for us to:

1. Process all insurance claims
2. Ensure payment for services provided
3. Release medical information to insurance companies needed for processing of your claims
4. Release information to other medical and dental providers, including laboratories, when necessary, for treatment.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information when necessary, to other providers rending medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance for my treatment. I assign all medical and surgical benefits, including major medical benefits to which I am entitled. to *Kitsap Dental* clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient or Responsible Party Signature:_____

Full Name (Printed):_____