

## **Piedmont Dentistry Appointment Policy**

Missed appointments or cancelled appointments not cancelled in an appropriate amount of time are a lost opportunity for us to help another patient. We ask that you make every effort to keep your reserved appointment and arrive on time. If you cannot make your appointment it is considered a *broken appointment*. It has always been our policy to charge for all broken appointments, below is a reminder of this policy.

We ask that you give us a **2 business day** notice of cancellation or to reschedule your reserved appointment.

**A charge of \$25.00 will be made for every 30 minutes of your broken appointment.**

Once your broken appointment charge has been paid we will offer to reschedule your missed appointment.

**In the event of a future broken appointment you will be required to pay a non-refundable deposit of \$25.00 per 30 minutes for all future appointments, including family members, before we will reschedule.**

It is your responsibility to advise our office of any changes to your address, contact telephone numbers or e-mail address. We send reminder post cards weeks in advance, additionally, we provide a service to remind and confirm your appointments, and if not confirmed our staff will attempt one final confirmation call 2 business days before your reserved time.

**Please take the opportunity to provide Piedmont Dentistry with your current contact information so we may update our records:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Names of family members you would like for us to include with this update and acknowledgement of the above broken appointment policy:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

\_\_\_\_\_ **By signing this appointment policy form you acknowledge and authorize that this office will charge the above mentioned fee for broken appointments.**

\_\_\_\_\_ **By signing this appointment policy you acknowledge that Piedmont Dentistry is not responsible to confirm your reserved time, but that it is done as a courtesy so we may remind you of the time you reserved.**

\_\_\_\_\_  
Signature of patient, Guardian of patient or Parents Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr. Gabrielle Williams, Piedmont Dentistry

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date