

APPOINTMENT CANCELLATION POLICY

I, _____ understand that it is my responsibility to kindly call and cancel or reschedule any appointment. I will do so 48 hours prior to my scheduled appointment, or I will leave a message on the office answering machine if the office is closed.

If an appointment is missed without calling in to cancel or reschedule I agree to pay a fee of 25% of my scheduled appointment. If three appointments are missed without appropriate notice, this office will no longer be able to reschedule you for further appointments.

I have read and understand my obligation as a patient/parent/patient representative to this office in regards to Lifetime Dental Care's appointment cancellation policy.

Signature

Date