

# *Cancellation and Broken Appointment Policy*

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We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us **48 hours'** notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

## **POLICY AND FEES:**

Cancellation or rescheduling of an appointment **with 48 hours or more** notification – **no charge**

Cancellation or rescheduling of an appointment is **not allowed over our answering service**; please speak to an employee directly.

## **FAILURE TO GIVE 48 HOUR ADVANCE NOTICE:**

- A **\$50** fee for a broken hygiene (cleaning) appointment.
- An **\$80** fee for a doctor's appointment scheduled for an hour or less, each additional hour incurs an additional fee of **\$80** (Two Hours: **\$160**).
- After a surgical appointment has been broken, there will be a **\$150** deposit fee put on your account for the services at a future date before another appointment can be scheduled.

## **DEFINITION OF "BROKEN APPOINTMENT": A BROKEN APPOINTMENT IS WHEN YOU:**

- **Cancel or reschedule** an appointment with less than 48 hour notice
- **Do not show up** for the scheduled appointment
- **Show up late 11min or More** to your appointment

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us at Dr A. Haeri Periodontics and Implants.

I have read and understand the above mentioned policy.

\_\_\_\_\_ Date\_\_\_\_\_

Patient signature (Parent or Guardian if minor)

Witness \_\_\_\_\_ Date: \_\_\_\_\_