First Name:_____ Last Name:_____

APPOINTMENT CANCELLATION AND NO SHOW POLICY

We require that appointment cancellation notification be given ***a minimum of 24 hours in advance***. With cancellations less than 24 hours in advance, we are unable to fill the appointment, resulting in lost time.

Appointments that are cancelled with less than 24 hour notice will result in a **$50 cancellation fee**.

The Cancellation and No-Show fees are the sole responsibility of the patient and will be due prior to your next appointment.

We understand that situations arise that you are unable to control that force you to cancel your appointment with less than 24 hours notice. Fees in this instance may be waived or reduced, but only with management approval.

Please sign below acknowledging your understanding of the appointment cancellation / no show policy.

_____ _____

Patient Signature Date

FINANCIAL GUIDELINES

Thank you for choosing The Village Dentistry. In efforts to better serve you, we would like to take the time to explain the billing process at our office.

Once you provide the office with your dental insurance, we call your insurance company to verify your benefits. The information we receive from your insurance company is **only an estimation** of coverage and **not a guarantee**. Payment due is due at the time of service (if you are using dental insurance, this includes your deductible and co-payment). After you have been seen in our office, we will file you claim to the insurance company directly. If the insurance company does not cover the estimated amount in full, you will receive a statement in the mail and be responsible for the remaining account balance.

Thank you again for choosing The Village Dentistry for your dental needs. We look forward to a long relationship with you.

I have read and understand the billing process at The Village Dentistry.

_____ _____

Patient Signature Date