Eastgate Dental Care

Dear Patients,

Our practice is updating and incorporating policies, effective immediately starting on **1/26/15.** With these policies in place, our practice will be able to serve you and your family better:

- **We will require a confirmation for all appointments.**
  - Our office uses emails, texts, and personal calls to remind all of our patients about their appointments.
    - If we have reached out to confirm your appointment, we will require you to contact us, letting us know you are coming to the appointment.
      - Simply calling and leaving us a message on the machine will suffice.
  - ***Failure to confirm your appointment will be treated as a cancelled appointment****, your time may be taken by another patient, and you may be subject a cancellation fee.*

- **24-Hour Cancellation Fee**
  - Cancellations not only hurt our practice, but also you, the patient, who could have been seen during that time slot.
    - Appointments must be cancelled at least 24 hours prior the scheduled time.
      - Any cancellations with less than 24 hour advanced notice will be considered a late cancellation and subject to our fee fee.
    - A **$55 dollar cancellation fee per individual,** may be applied to patient's balance.
    - Our practice reserves the right to require a credit card on file, before any future appointments can be made.

- **Updated Patient information**
  - It is **patient's responsibility** to ensure that our office is up to date regarding your personal information.
    - Having most up to date contact information (address, phone/cell/work numbers, and email) are all vital for us to better serve you.
    - Having the correct dental insurance information is essential in processing your dental claims correctly.

- **Insurance and Financial Policy**
  - *Ultimately, you are responsible for all charges incurred in our office.*
  - If you have dental insurance, the person(s) responsible for the account balance will be required to read over and sign our financial policy form.

I have read, understand, and agree to the conditions stated above as they apply to me

Print Name: _____Date: _____

Patient/Parents Signature: _____