FAIRMONT DENTAL ASSOCIATES

GENERAL AND COSMETIC DENTISTRY
COMPLETE ORAL CARE CENTER FOR YOU AND YOUR FAMILY

Cancellation and No-Show policy

Office hours are by appointment and we do value your time. Appointment times are reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will understand the situation. At some point they may need the same courtesy too!

We do make great effort to confirm our appointments. Please provide us with your cell number and email address to help us in reminding you of your appointment efficiently. When you make an appointment we look forward to seeing you at your next visit. If you must have to cancel an appointment, we do ask you to notify our office at least 24 business hours in advance so we can be fair to other patients who may need our attention sooner than their appointment.

There is a charge for not showing up for the appointment or failing to cancel your appointment before 24 business hours. The amount will depend on the length and procedure of the appointment. The cancellation charge will be waived only if the office can make another patient appointment for that time. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. You can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

I certify that I have read and understand the cancellation-no show policy. I have been given the opportunity to ask any question or concern. I do understand that I will be held accountable to any financial obligation under the guidelines of this policy.

Signature_____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have read/received a copy of this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving away my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I also hereby authorize this office to take photograph, slides, and/or video of my face, jaws, teeth. I understand that the photograph, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstration, advertising (including website publication, newspaper, magazines, phone book,TV), and professional publication (dental magazines and journals). I further that if the photographs, slides, and/or videos are used in any publication or as a part of the demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us.

Signature: _____ **Date:**_____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my personal health information for treatment, payment, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____**Date:**_____