Febres Dentistry for Children, PA

Cancellation and Missed Appointment Policy

Child's Name: _____ Child's Name: _____

Child's Name: _____ Child's Name: _____

Place parent initials on each line to confirm you have read the statement.

_____ I understand I will be charged a LATE CANCELLATION fee of $28 if I fail to give at least 24 hour notice prior to cancelling my appointment. If I am not able to contact verbally a staff member, I will leave a voicemail with full name, appointment time and other details.

_____I understand that I will be charged a NO-SHOW fee of $28 if I fail to show for my appointment.

_____ I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

_____ I understand that the office reserves the right to reschedule my appointment if I am more than 10 minutes late. A cancellation fee of $28 will be charged.

_____**** Medicaid / Chip patients**: Although a cancellation fee may not be applied, after the 3rd missed appointment or late cancellation, we will have to decline our services since our policies do not match your needs.

By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from Febres Dentistry for Children.

Parent/ Guardian (name) _____ Relationship: _____

Signature: _____ Date: _____