FEISAL OSMAN
FAMILY DENTISTRY
YOUR SMILE MATTERS

Office and Policy Consent Form

CANCELLATION AND BROKEN APPOINTMENT POLICY

A reserved appointment time in any dental office is limited and valuable. It is extremely important that all our patients honor their reserved dental appointments.

Those who fail to keep their scheduled appointments should not penalize the Dentist, our staff, and mainly our other patients. Our dental policy stipulates that failure to give sufficient notice to keep a scheduled appointment will result in a fee being charged. That charge is in accordance with our dental office's broken appointment policy for all of our patients. The patient is responsible for the payment of the charge.

- **Cancellation or rescheduling of an appointment with 48 hours' notice or more notification – NO CHARGE**

- **Cancellation, rescheduling, or failure to show-up for a scheduled appointment with less than 24 hours' notice will be charged the following:**

$25 FOR ALL APPOINTMENTS

After a third missed or canceled appointment without 24-hour notice, the patient may be dismissed from the practice at our discretion.

Every effort is made to contact patients to confirm. Our staff will contact you 1 days prior to your scheduled appointment to confirm with you. Please understand that this is a courtesy call, text, or email. If we are unable to reach you, your appointment texts or emails will serve as your confirmation of the appointment and implies your obligation to be present.

FINANCIAL POLICY

We accept cash, checks, Care Credit, and all major credit cards (Visa, MasterCard, American Express, and Discover). Payment for dental service is expected and required at the time of service, unless other arrangements have been made. Payment plans will require a credit card on file and will not exceed 6 months. Treatment appointments made will require a $50 down payment prior to treatment.

Although we do accept the assignment of most insurance companies, your insurance is an agreement between you and your insurance company. We will do our best to see that you receive your full benefits.

Patient's Signature: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Relationship to Patient: _____

Please Print Patient Name: _____