



Appointment Late Cancellation/No Show Policy

Ocala Dental Care is privileged to provide dental care and dental surgeries to our patients. We work diligently to maintain our high level of personalized service and strive to accommodate our patients' needs for office visits in a timely manner.

This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of our patients. Therefore, we have developed this policy regarding failure to keep appointments or cancelling without adequate notice.

We respectfully request your understanding and agreement to our policy as it is stated below.

Office Appointments

We will give you a reminder call 48 hours prior to your scheduled appointment and a same day reminder text. Any patient who fails to keep an appointment or who cancels or reschedules less than 24 hours prior to their standard dental appointment or 48 hours in advance to a surgical appointment, will be required to pay the applicable fee in order to schedule a new office visit. For any appointments on a Monday, the Friday prior to the appointment is the last day to make any and all appointment changes. Fees range according to appointment type; this includes \$45 for dental hygiene, \$100 per hour of Doctor Time for a standard appointment and surgical appointments which are subject to a percentage of the appointment cost in consideration of time/setup/materials cost. This fee must be paid prior to rescheduling your next appointment or reserving any further time on our schedule.

Fees

Any fees charged are not payable by your insurance company. All fees must be paid on or before your next appointment. If a patients fails 3 or more appointment, Ocala Dental Care has the right to dismiss the patient from the practice.

Thank you for your understanding of our policy.

Patient Signature

Date
