MARK BALENSEIFEN DDS - PROSTHODONTIST
415 E. Main St. Suite #4
Yukon, OK 73099-2259
405-467-4092

PATIENT POLICY FORM

We value your appointments and your time. To ensure you receive the most benefit from these services we ask that you attend all scheduled appointments. However, we understand emergencies happen. In order to better serve our patients we ask that you read the following terms and sign and date this form.

I agree to cancel all scheduled appointments at least 24 hours in advance of the appointment date. I understand if I do not, I will be charged a $25.00 late cancellation fee.

I understand that if I do not show up for my scheduled appointment, I will be charged a no show fee of $25.00. (A no show fee of $50.00 applies to all prophylaxis appointments.)

I agree to pay any late charge I accrue, in full, before or on my next appointment.

I understand that I am to arrive at my appointments on time and that if I am more than 10 minutes late for my appointment, I may need to be rescheduled.

I understand that I am responsible to contact the office to reschedule any appointment I cancel or any appointment I do not show up for.

I understand I will be left a courtesy reminder call for my appointment, but it is my responsibility to remember my appointment date and time.

I understand that after 2 no shows or late cancellations my case will be reviewed and I may be referred to another dental office for future services.

I agree to keep all my contact information current and up to date. If my address or phone numbers change I will inform the front office of these changes.

I understand that if my insurance coverage changes I need to supply the front office with the new insurance information.

I understand that consistent attendance is necessary to achieve the goals in my dental care. I understand that inconsistent attendance may prolong these goals from being achieved, and may result in the ending of services. I understand if services are ended, I will receive a referral to another dental office.

_____ _____

Patient (or Guardian) Signature Date Staff Signature Date