Patient Name: ____________________

Confirmation Policy

In order to provide you with the most quality care, 7 Days Family Dental is now implementing an appointment confirmation policy. This confirmation policy will help us provide you with the timely services you deserve. **If you cancel your appointment in less than 24 hours or do not show up, you will be charged a $50.00 fee.**

We will call or text you two (2) days prior to your dental appointment. If we do not hear from **you within 24 hours of your appointed time, we will cancel the appointment** and schedule emergency patients. **If you are late to your scheduled appointment you could be asked to reschedule.**

Any patient missing (3) appointments within one year without making prior arrangements to either reschedule or cancel with our office will be placed on a same-day service restriction. Patients on this restriction will need to contact our office on the day they are seeking an appointment and we will try to accommodate within our schedule for that day. We do understand emergencies can arise. We only ask that our patients please contact our offices as soon as possible in such circumstances. We are committed to providing you with the best care.

I have read and understand the appointment policy.

________________________ ____________________

Patient Signature Date