KOCIAN FAMILY DENTAL
YOUR HOMETOWN DENTIST

24 Hour Cancellation Policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notice allows us to fulfill other patient's scheduling needs and keeps the dental office operating at the most efficient level. Due to our one-on-one scheduling; missed appointments are a significant inconvenience to your dentist, the office, and other patients.

This policy is in place out of respect for our Dentist AND our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot, and leave a gap in our schedule.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled hygiene appointment may be responsible for a $50.00 service charge. For Dr. Kocian missed treatment appointments a $75.00 service charge. If your appointment was scheduled for over an hour and a half a $100.00 service charge will be due. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. We will allow the fee to be waved of $50 and $75 one time.
2. We reserve your one-hour appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to offer that time to a wait-listed patient.
3. After two missed or cancelled appointments without the appropriate 24-hour notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

NOTE: You will never be charged for a cancellation if it is made more than 24 hours in advance for your schedule appointment time. We do understand true emergencies and that will not affect your scheduling.

Thank you for providing our office and our patients with this courtesy. I have read, understand, and agree to abide by the policy above.

Print Name: _____

_____ _____

Signature of Patient (or Responsible Party) Date