Notice of Business Policies

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____, have read a copy of Angel Dentistry's notice of Privacy Policies. I understand that a copy of this notice has been made available to me for my records, upon my request.

_____
Patients Name (Print)

_____ _____
Patient, Parent or Legal Guardian's Signature Date

Notice of Cancellation or No Show Appointments

Angel Dentistry respects the time of out patients. We understand that time is precious; we work very hard to run on time in order to accommodate you. With this in mind please understand that we rely on each patient's ability to keep their appointments. Also, understand that emergencies do happen and as hard as we try to stay on time we feel it is very important to give each patient an understanding and caring approach to dentistry.

Our policy is as follows:
Appointments that have been scheduled on **Monday-Thursday** require a **24-hour cancellation notice**. If an appointment is missed or cancelled less then 24 hours of the scheduled appointment a **$50.00 fee** will be added to the patient balance. As you can imagine appointments that are scheduled on **Fridays and Saturdays** are the most requested, thus we require a **48-hour cancellation notice**. If an appointment is missed or cancelled less then 48-hours of the scheduled appointment a **$100.00 fee** will be added to the patient balance.

Angel Dentistry does try to give a courtesy call prior to the scheduled appointment. However, it is expected that you keep your appointment that you scheduled with or with out a courtesy call.

Thank you for you understanding.

_____ _____
Patient or Legal Guardian Signature Date