Vista Ridge Dental

8409 West Cleburne Rd • Fort Worth, TX 76123 • (817)292-5927

www.vistaridgedental.com

info@vistaridgedental.com

Patient Information

Patient Name: ______________________________
Last First MI Preferred Name

Title: ____________ Mr / Ms / Mrs / etc **Gender:** O Male O Female **Family Status:** O Married O Single O Child O Other

Birth Date: ______________________ **SS#:** ______________________

Drivers License #: ______________________ **Previous Visit:** ______________________

Email Address: ______________________ **Best time to call:** ______________________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ______________________ ______________________
Address 1 Address 2

______________________ ____________ ____________
City State Zip Code

Referral Information

Name of person, office or other source referring you to our practice: ______________________

Spouse or Responsible Party Information

The following is for: O the patient's spouse O the person responsible for payment O Skip - the patient is responsible or not married

Name: ______________________________
Last First MI Preferred Name

Title: ____________ Mr / Ms / Mrs / etc **Gender:** O Male O Female **Family Status:** O Married O Single O Child O Other

Birth Date: ______________________ **SS#:** ______________________

DL#: ______________________

Email Address: ______________________ **Best time to call:** ______________________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ______________________ ______________________
Address 1 Address 2

______________________ ____________ ____________
City State Zip Code

Employment Information

The following is for: O the patient O the person responsible for payment

Employer Name: ______________________ **Phone:** ______________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ____________ ____________
City State Zip Code

Primary Dental Insurance

Name of Insured: ____
Last First MI

Insured's Birth Date: ________________ **ID#:** ________________ **Group#:** ________________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______________ ______________
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______________ ______________
City State Zip Code

Patient's relationship to insured: O Self O Spouse O Child O Other

Insurance Plan Name: ____

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______________ ______________
City State Zip Code

Secondary Dental Insurance

Name of Insured: ____
Last First MI

Insured's Birth Date: ________________ **ID#:** ________________ **Group#:** ________________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______________ ______________
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______________ ______________
City State Zip Code

Patient's relationship to insured: O Self O Spouse O Child O Other

Insurance Plan Name: ____

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______________ ______________
City State Zip Code

Emergency Contact Information

Please list the name and phone number of someone to notify in case of an emergency:

Name: ______________________________ Phone: ______________________

Please list the name and phone number of your physician:

Name: ______________________________ Phone: ______________________

Signature: X______________________________ **Date:** ________________

DENTAL INFORMATION

Patient Name: ____

Last First MI

Primary reason for this appointment: O Examination O Emergency O Consultation

Do you have a specific dental problem today? O Yes O No

If yes, please explain: ____

Do you have dental examinations on a routine basis? O Yes O No

Last visit?: ____

Do you brush your teeth on a routine basis? O Yes O No

How often?: ____

Do you floss on a routine basis? O Yes O No

How often?: ____

Do you like your smile? O Yes O No

If no, why?: ____

Do you think you have active tooth decay? O Yes O No

Do you think you have gum disease? O Yes O No

Do your gums bleed? O Yes O No

Do you have any loose teeth? O Yes O No

Have you ever had any periodontal (gum) treatments? O Yes O No

If yes, when and where?: ____

Do you want to keep your remaining teeth? O Yes O No

Do you ever have clicking, popping, or discomfort in the jaw joint? O Yes O No

Do you brux or grind your teeth? O Yes O No

Do you smoke or chew tobacco? O Yes O No

Have you ever had orthodontic (braces) treatment? O Yes O No

Do you wear dentures or partials? O Yes O No

If yes, are you satisfied with them?: ____

Have you had any problems associated with previous dental treatment? O Yes O No

If yes, please explain: ____

Name of previous dentist (optional): ____

Date of last full mouth x-rays (16 small films or panoramic): ____

Medical Information

Patient Name: ____

Last First MI

Are you now under the care of a physician? O Yes O No

Physician Name: ____

Physician Phone Number: ____

Has there been any change in your general health within the past year? O Yes O No

If yes, please specify: ____

Have you had a serious illness, operation or been hospitalized in the past 5 years? O Yes O No

If yes, what was the illness or problem?: ____

Please indicate if you have or have had any of the following diseases or problems:

Have you had an orthopedic total joint replacement? O Yes O No

If yes, please specify: ____

Are you scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's Disease? O Yes O No

If yes, please specify: ____

Since 2001, were you or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, Xgeva) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma or metastatic cancer?
O Yes O No

Date treatment began: ____

Do you have any cancer history in your family? O Yes O No

If yes, who and what type of cancer?: ____

For Women Only:

Are you pregnant? O Yes O No

If yes, how many weeks?: ____

Are you taking birth control pills or hormonal replacement medications? O Yes O No

Are you nursing? O Yes O No

Have you had a positive pap smear? O Yes O No

Please indicate if you have or had any of the following diseases or problems. (The following marked with an * require premedication with antibiotics before any dental treatment is done):

Artificial (prosthetic) heart valve * O Yes O No

Previous infective endocarditis * O Yes O No

Damaged valves in transplanted heart * O Yes O No

Congenital heart disease (CHD) * O Yes O No

If you have congenital heart disease (CHD), please indicate if you have had:

☐ Unrepaired cyanotic CHD *

☐ Repaired CHD (completely) in the last 6 months *

☐ Repaired CHD with residual defects *

ALLERGIES

Do you have, or have you had any of the following allergies?:

Allergy	Yes / No	Please explain
Acrylic Allergy	O Yes O No	Please explain: ____________
Animal Allergy	O Yes O No	Please explain: ____________
Aspirin Allergy	O Yes O No	Please explain: ____________
Barbituates/Sedative Allergy	O Yes O No	Please explain: ____________
Codeine Allergy	O Yes O No	Please explain: ____________
Erythromycin Allergy	O Yes O No	Please explain: ____________
Food Allergy	O Yes O No	Please explain: ____________
Hay fever/Seasonal Allergy	O Yes O No	Please explain: ____________
Iodine Allergy	O Yes O No	Please explain: ____________
Latex (Rubber) Allergy	O Yes O No	Please explain: ____________
Local Anesthetics Allergy	O Yes O No	Please explain: ____________
Metal Allergy	O Yes O No	Please explain: ____________
Penicillin Allergy	O Yes O No	Please explain: ____________
Sulfa Drug Allergy	O Yes O No	Please explain: ____________
Tetracycline Allergy	O Yes O No	Please explain: ____________
Other Allergy	O Yes O No	Please explain: ____________

MEDICAL CONDITIONS

Do you have, or have you had any of the following medical conditions:

Condition	Yes / No	Please explain
Abnormal bleeding	O Yes O No	Please explain: ____________
AIDS or HIV infection	O Yes O No	Please explain: ____________
Anemia	O Yes O No	Please explain: ____________
Angina	O Yes O No	Please explain: ____________
Arteriosclerosis	O Yes O No	Please explain: ____________
Arthritis	O Yes O No	Please explain: ____________
Asthma	O Yes O No	Please explain: ____________
Autoimmune disease	O Yes O No	Please explain: ____________
Blood transfusion	O Yes O No	Please explain: ____________
Bronchitis	O Yes O No	Please explain: ____________
Cancer treatment (Chemo/Radiation)	O Yes O No	Please explain: ____________
Cardiovascular disease	O Yes O No	Please explain: ____________
Chest pain upon exertion	O Yes O No	Please explain: ____________
Chronic obstructive pulmonary disease (COPD)	O Yes O No	Please explain: ____________
Chronic pain	O Yes O No	Please explain: ____________
Congestive heart failure	O Yes O No	Please explain: ____________
Coumadin/blood thinner therapy	O Yes O No	Please explain: ____________
Damaged heart valves	O Yes O No	Please explain: ____________
Diabetes I or II	O Yes O No	Please explain: ____________
Eating disorder	O Yes O No	Please explain: ____________
Emphysema	O Yes O No	Please explain: ____________
Epilepsy	O Yes O No	Please explain: ____________
Excessive urination	O Yes O No	Please explain: ____________
Fainting spells or seizures	O Yes O No	Please explain: ____________
GE reflux/persistent heartburn	O Yes O No	Please explain: ____________
GI disease/stomach problems	O Yes O No	Please explain: ____________
Glaucoma	O Yes O No	Please explain: ____________
Heart attack	O Yes O No	Please explain: ____________
Heart murmur	O Yes O No	Please explain: ____________
Hemophilia	O Yes O No	Please explain: ____________
Hepatitis, jaundice or liver disease	O Yes O No	Please explain: ____________
High blood pressure	O Yes O No	Please explain: ____________
High cholesterol	O Yes O No	Please explain: ____________

Condition			
Human papillomavirus (HPV) infection	O Yes	O No	Please explain: ______________________________
Kidney problems	O Yes	O No	Please explain: ______________________________
Low blood pressure	O Yes	O No	Please explain: ______________________________
Malnutrition	O Yes	O No	Please explain: ______________________________
Mental health disorders	O Yes	O No	Please explain: ______________________________
Mitral valve prolapse	O Yes	O No	Please explain: ______________________________
Neurological disorders	O Yes	O No	Please explain: ______________________________
Night sweats	O Yes	O No	Please explain: ______________________________
Osteoporosis	O Yes	O No	Please explain: ______________________________
Other congenital heart defects	O Yes	O No	Please explain: ______________________________
Pacemaker	O Yes	O No	Please explain: ______________________________
Persistent swollen glands in neck	O Yes	O No	Please explain: ______________________________
Recurrent infections	O Yes	O No	Please explain: ______________________________
Rheumatic fever	O Yes	O No	Please explain: ______________________________
Rheumatic heart disease	O Yes	O No	Please explain: ______________________________
Rheumatoid arthritis	O Yes	O No	Please explain: ______________________________
Severe headaches/migraines	O Yes	O No	Please explain: ______________________________
Severe or rapid weight loss	O Yes	O No	Please explain: ______________________________
Sexually transmitted disease	O Yes	O No	Please explain: ______________________________
Sinus trouble	O Yes	O No	Please explain: ______________________________
Sleep disorder	O Yes	O No	Please explain: ______________________________
Snoring	O Yes	O No	Please explain: ______________________________
Stroke	O Yes	O No	Please explain: ______________________________
Systemic lupus erythematosus	O Yes	O No	Please explain: ______________________________
Thyroid problems	O Yes	O No	Please explain: ______________________________
Tuberculosis	O Yes	O No	Please explain: ______________________________
Ulcers	O Yes	O No	Please explain: ______________________________
Other medical condition	O Yes	O No	Please explain: ______________________________

MEDICATIONS

Are you currently taking any of the following medications?:

Medication			
Aleve/Naproxen	O Yes	O No	Name of medication and how often taken: ______________________________
Antibiotic	O Yes	O No	Name of medication and how often taken: ______________________________
Antidepressant Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Anxiety/Sedative Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Arthritis Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Aspirin	O Yes	O No	Name of medication and how often taken: ______________________________
Birth Control/Hormone Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Bladder Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Blood Pressure Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Blood Thinner Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Cancer Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Cholesterol Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Cold/Cough Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Decongestant	O Yes	O No	Name of medication and how often taken: ______________________________
Diabetes Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Dietary Supplement	O Yes	O No	Name of medication and how often taken: ______________________________
Diuretic/Kidney Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Epilepsy/Seizure Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Heart Medication	O Yes	O No	Name of medication and how often taken: ______________________________
Ibuprofen	O Yes	O No	Name of medication and how often taken: ______________________________
Inhaler/Respiratory Medication	O Yes	O No	Name of medication and how often taken: ______________________________

Natural/Herbal Medication	O Yes O No	Name of medication and how often taken: ____________________________
Osteoporosis/Bone Medication	O Yes O No	Name of medication and how often taken: ____________________________
Pain Medication	O Yes O No	Name of medication and how often taken: ____________________________
Prostate Medication	O Yes O No	Name of medication and how often taken: ____________________________
Seasonal Allergy Medication	O Yes O No	Name of medication and how often taken: ____________________________
Thyroid Medication	O Yes O No	Name of medication and how often taken: ____________________________
Tylenol	O Yes O No	Name of medication and how often taken: ____________________________
Ulcer/Heartburn Medication	O Yes O No	Name of medication and how often taken: ____________________________
Vitamin	O Yes O No	Name of medication and how often taken: ____________________________
Other Medication	O Yes O No	Name of medication and how often taken: ____________________________

Do you use controlled substances? O Yes O No

Please specify: ____

Do you drink alcoholic beverages? O Yes O No

If yes, how much alcohol have you drank in the last 24 hours?: ____

If yes, how much do you typically drink in a week?: ____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? O Yes O No

Name of physician/dentist: ____

Phone number of physician/dentist: ____

Do you have any disease, condition, or problem not listed above that you think we should know about? O Yes O No

Please explain: ____

Authorization and Consent

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I will not hold the dentist, or any other staff member, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of these forms. I hereby consent to and authorize the dental office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I further understand that payment is due at the time of treatment unless prior arrangements have been made. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. Furthermore, I grant the dental practice permission to correspond to me via e-mail and/or text message.

Signature of Patient, Parent, or Guardian (Responsible Party):

Signature: X____ **Date:** ____________________

Relationship to Patient: ______________________________

OUR FINANCIAL POLICY

PAYMENT: Payment is expected in full for each appointment as services are rendered. Payment options are:

- Cash
- Debit
- Major credit cards (MasterCard, Visa, Discover, American Express)
- CareCredit

DENTAL INSURANCE: Insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Dental services can be defined by your insurance company as “not covered”, “denied”, or “over UCR (Usual, Customary & Reasonable)”. We will file your dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions, and provisions determined by your insurance company. You agree to pay any of the charges not paid by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for it. We will file a predetermination for recommended treatment when you request it.

REGARDING APPOINTMENTS: Any treatment that is over $500 in estimated patient payment will require a prepaid non-refundable deposit of $100 in order to reserve a scheduled appointment time for treatment.

BILLING: Any balance we bill you, is due upon receipt. If any payment owed by you is not made within 30 days, a delinquent fee of 29% will be added to your account.

I have read, understand, and agree to the above Financial Policy. I authorize release of any information relating to any insurance dental claim filed on my behalf. I hereby instruct and direct the insurance company to pay by check made out and mailed to John Avila DDS, or if my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct the insurance company to make out the check to me and mail it as follows: c/o John Avila DDS, 8409 West Cleburne Road, Fort Worth, TX 76123. I authorize Dr. Avila to deposit checks received on my account when made out to me. By signing this form, I also authorize Dr. Avila to complain to the Insurance Commissioner for any reason on my behalf.

Patient or Responsible Party X________________________________ **Date**___________

(Signature)

VISTA RIDGE DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: John Avila DDS

Telephone: (817) 292-5927 Fax: (817) 292-9595

E-mail: info@vistaridgedental.com

Address: 8409 West Cleburne Road, Fort Worth, TX 76123

ACKNOWLEDGEMENT: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

X____________________________________ ____________________

Signature (Patient / Legal Representative) Date

VISTA RIDGE DENTAL

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____ give Vista Ridge Dental/John Avila
Name
DDS permission to release and speak to the following people about my health information, treatment, and/or account:

1. ____

2. ____

3. ____

Signature (patient or legal representative) X____________________________________

Date ____

APPOINTMENT CANCELLATION POLICY

We strive to render excellent care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **48 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that allotted time. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$70** will be charged to you. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor records be transferred without payment of this fee.

Additionally, if a patient is more than **15 minutes late** without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$70** cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound to its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Patient or Responsible Party X______________________________ **Date**______________

(Signature)