

Paradise Family Dentistry

"No Show" /Cancellation Policy

*Welcome and thank you for choosing Paradise Family Dentistry! If you have any questions or concerns, do not hesitate to ask for assistance.
We will be happy to help.*

Your appointment is important to us and to your health. If you miss an appointment, it may delay the treatment you need. You may also have to wait longer than you would like for a new appointment date. We do not want to keep you waiting.

Because of the tight scheduling at Paradise Family Dentistry, it is very important that you keep each appointment and arrive promptly at the time the appointment is scheduled. For our part, we will do our best to see you at the scheduled time and provide you with professional, quality care.

If you must change your appointment, in consideration for others, please call us at least 24 hours in advance to cancel or change your appointment. If it is after normal business hours, you may leave a voice message.

If you fail to keep an appointment without notifying our office in advance on three occasions within a calendar year, consecutive or otherwise, we will not be able to schedule further appointments for you. We will give you a courtesy reminder call 2-3 business days prior to your appointment. If we do not hear from you by the end of the 2nd business day, your appointment may be cancelled or pushed to the side. We still may be able to fit you in, but your appointment will no longer be first priority. Therefore, if you are more than 15 minutes late, or if you fail to confirm your appointment, your appointment will be subject to be rescheduled.

We understand there may be times you will miss an appointment due to family emergency or obligations and we will take these situations into account, however, we strongly encourage you to inform us within one business day prior to your reserved appointment so that we can accommodate another patient in that time slot. We greatly appreciate your understanding and cooperation with this policy.

My signature below indicates that I have read the above policy and that I understand it.

X _____
Patient Name / Signature

_____/_____/_____
Date

X _____
Responsible Party

_____/_____/_____
Date

Please notify our office with any changes to your contact numbers and/or address