

Richard Thibodeau D.M.D

Appointment Cancellation/Financial Policy

We strive to render excellent dental 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 most effectively. When an appointment is scheduled, that time has been set aside for you and when it is missed without proper notice, we cannot utilize your allotted appointment time for another patient.

Our Policy is as follows:

We require that you give our office a **full business day (24 hours)** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled during that time. If you miss an appointment without contacting our office within the required time frame (24 hours), this will be considered a missed appointment. A fee of **\$50** 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 without the payment of this fee.

Additionally, if you are more than 20 minutes late without prior notice for a scheduled appointment, you may have to reschedule your appointment to a later date.

We understand that some appointments are established several months prior to date of service. Our team strives to minimize forgotten appointments by providing a reminder call to each patient approximately one week prior to their scheduled appointment time. It is important to respond with confirmation for your scheduled appointment.

If you have any questions regarding this policy, please notify our team. We will be glad to clarify any questions you have.

Our Financial Policy

Payment is due at time of service. For your convenience, we take Care Credit, Checks, Credit and Debit Cards. Also, all accounts with an outstanding balance exceeding 90 days will be transferred to a collection agency. If your account is transferred to a collection agency, you will be responsible for a **35% collection fee** of your unpaid balance.

Thank you for your patronage.

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

I, _____ (Print Name), have read and understand Richard Thibodeau D.M.D., Appointment Cancellation/Financial Policy.

Signature of Patient or Guardian _____ Date: _____