

Shelly's Smile Neighborhood Dental

Notice of Privacy Practices Acknowledgement

I, _____, hereby acknowledge that I have reviewed this practice's Notice of Privacy Practices. I understand that I may request a copy at anytime. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient Signature: _____ Date: _____

Cancellation Policy

Any appointment made at Shelly's Smile Neighborhood Dental is an agreement between you, the patient, and our office. If you must reschedule your appointment please extend us the courtesy of a 24 hour notice. On occasion we might have to reschedule the patient's appointment due to a change in the Doctor / Hygiene Schedule. Shelly's Smile Neighborhood Dental has a Broken Appointment Fee assessed each time an appointment is broken. That fee is \$35.00. That fee must be paid in full before scheduling a new appointment. The patient is responsible for paying that charge.

By signing below, I _____ understand that if I fail to provide a 24 hour notice to Shelly's Smile Neighborhood Dental I will be charged \$35.00.

Patient Signature: _____ Date: _____

Staff Witness Signature: _____ Date: _____