



## **Late Cancellation and No-Show Guidelines**

### **Patient Agreement Form**

We strive to provide the highest level of care to all our patients and want to ensure that every scheduled appointment is respected and honored. To assist in maintaining an efficient schedule and to provide access to appointments for other patients, we have established the following Late Cancellation and No-Show Guidelines.

#### **Cancellation Notice**

We require at least 24 hours' notice if you need to cancel or reschedule an appointment. Cancellations made with less than 24 hours' notice may be considered a late cancellation.

#### **No-Show Policy**

If you miss your scheduled appointment without notifying us 24 hours in advance, this will be considered a No-Show. Repeated late cancellations or no-shows may affect your ability to schedule future appointments.

#### **Day of Only Policy**

After two late cancellation or no-show, you may be switched to "Day of Only" status. This means that future appointments can only be scheduled on the same day, subject to availability. This policy helps us ensure that your commitment to attending scheduled appointments is respected and allows us to offer available time slots to other patients.

#### **Dismissal Policy**

After three late cancellations or no-shows, you may be subject to possible dismissal from our practice. This policy helps us maintain timely access to care for all our patients and ensures we can continue to provide quality service.

#### **Exceptions**

We understand that emergencies may arise, and we will make exceptions on a case-by-case basis. Please inform us as soon as possible if you are unable to attend your appointment due to an emergency or unforeseen circumstance. We reserve the right to consider these circumstances when determining the next steps.

#### **Confirmation of Appointment**

We send appointment reminders as a courtesy. However, it remains your responsibility to remember and keep your scheduled appointments.

By signing below, you acknowledge that you have read, understand, and agree to abide by the Late Cancellation and No-Show Guidelines of Blue Diamond Family Dental.

**Patient Name (Printed):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_