A to Z Pediatric Dentistry (A2ZPD)
No-Show/Cancellation Policy

PURPOSE: The Dr's and Staff at A2ZPD respects your time and we ask for the same courtesy. Missed appointments/no-shows affects our ability to provide timely attention to our patients. When a patient does not show up for their appointment, another patient loses an opportunity to be seen. If you are unable to make your appointment, we respectfully ask that you notify our office **24 hours in advance**. Failure to cancel an appointment with a 24 hour advance notice from your child's appointment time will be considered a no-show and you will be charged.

- If a confirmation call was documented and the patient fails to appear for his/her appointment, a no-show will be documented in the patient's chart. You will be billed as follows:
  - Cleaning or exam = $45
  - Nitrous treatment = $80
  - Oral/IV Sedation = $195
- If there is a pattern of no-shows or last minute cancellations, your child(ren) may be dismissed from the Practice.

I have read the above and understand A2ZPD's policy. I will do everything I can to assure that when I have confirmed an appointment, I will arrive on that specified day and time. I also understand that there may be extenuating circumstances that arise in which I have to make a last minute cancellation, we at A2ZPD understand this when situations arise and will try to be accommodating with rescheduling your child(ren). **IT IS ABSOLUTELY NECESSARY THAT YOU CALL OR RETURN TEXT AND CONFIRM ALL APOINTMENTS OR YOUR APPOINTMENT WILL BE CANCELLED.**

Initial: _____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Joel R. Clark and Dr. Trevor M Jensen, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill or services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

Initial: _____

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission to be obtained from a parent or legal guardian before any dental services can be rendered. I give ***my consent*** *to* the Dr's at A2ZPD and staff to perform such treatment, services, medications, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

Initial: _____

CONSENT TO ACCOMPANY IF APPLICABLE

Child/Children's full name(s): _____

DOB's: _____ _____ _____

I, _____ give _____ permission to accompany my child(ren) to the office of A2ZPD for dental appointments. I also give the above authorized person to make any necessary decisions regarding dental treatment for my child(ren) Including but not limited to:

- The consent for this authorized person to sign any and all forms required to give permission to A2ZPD to treat the dental needs of my child(ren).
- The consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges, etc) with this authorized person.
- The consent to the dental practice to discuss my child's future dental treatment needs (i.e. treatment plan).
- The consent for this authorized person to sign my child's treatment plan once it has been presented by the dental staff. I understand this does not obligate me to the treatment, only that the office has informed me or my representative of the dental needs of my child(ren).

I understand this consent will be valid until I rescind this agreement in writing.

Signature of Parent or Legal Guardian: _____ Date: _____