**UNION FAMILY DENTAL**

 **PATIENT APPOINTMENT POLICIES**

We at **UNION FAMILY DENTAL (UFD)** believe that the best relationships are based on mutual respect. We believe both your time and our time is valuable and should be respected. We strive to keep our schedule organized and on time in order to minimize wait time, while maximizing your time here. We therefore ask that you read and agree to the below patient polices.

**CANCELLATIONS:** **UFD** **requires 24 hour notice of any cancellations**. Cancellations without 24 hours of appointment may be considered a failure. We are aware and understand that emergencies due arise and we will review on a “case by case” basis.

**FAILURES:** **Listed below is the failure policy**

 FIRST & SECOND FAILED APPTS (within twelve month period)

 Appointments will be rescheduled

 THIRD FAILED APPT (within twelve month period)

 Appointment will be rescheduled, but you will be seen on a **“STANDBY BASIS**

 **ONLY”**. You can still be seen at UFD, but you will **not be given a guaranteed**

 **slot**. After three “STANDBY” APPOINTMENTS, you will be able to schedule

 a guaranteed appointment time for future appointments.

**APPOINTMENT TIMES**: **UFD**

**We grant a ten minute grace period to arrive at your appointment. AFTER TEN**

**MINUTES, your appointment may be rescheduled**, based on the schedule time

available, and the reason for the delay. We at UFD strive very hard to stay on

schedule, so as not to waste your time, and we appreciate the same for our time.

 **APPOINTMENT CONFIRMATION:**

Union Family Dental office policy requires you to confirm your appointment by 2pm the day before scheduled appointment. **The office will make two (2) attempts within 48 hour time span to reach you. Unfortunately, if we do not receive a response OR if unable to reach you, we will be required to move the appointment to standby status.**

Please feel free to leave a message if the office is closed or phones are busy, 704-776-4157.

 **We therefore ask that since you read this and agree to the above patient policies.** Your

 signature merely represents a good faith agreement between our patients and UFD.

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

 Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Patient(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised April 2015