



THE DENTAL SPECIALTY CENTER

FALCON

7520 Bierstadt Heights #125
Falcon, CO 80831
(719)-654-0105

Office Policies

It is the sole responsibility of the patient to provide us with the correct insurance information. We will provide you with a treatment plan and an estimate of treatment. Although we strive to give you the most accurate information, your benefits quoted are not a guarantee of payment and they are subject to current plan provisions, age limitations and eligibility. Your insurance company is the final determinate of exact cost to the patient. Your estimated patient portion/responsibility is due the day service is provided. Children under the age of 18 must be accompanied by an adult.

No-Show/Missed Appointment Policy

- A No-Show or a Missed Appointment is any scheduled appointment that you do not show up for or do not cancel **24 - business hours in advance**. Cancellations for a Monday appointment must be done prior to the close of business on Friday. Your advance notice of not being able to keep the appointment allows us to fill the opening.
- 1st No-Show – may be charged up to \$50.00.
- 2nd No-Show – may be charged up to \$75.00.
- 3rd No-Show – may be charged up to \$100.00 and review for dismissal from the practice.

Cancellation and Late Arrival

- Please call to reschedule or cancel any appointment 24 - business hours in advance to avoid a missed appointment fee.
- If you are late, the doctor or hygienist may have to reschedule the appointment and may assess a fee.
- Please be assured we will always do everything we can to respect your time and offer to accommodate minor variations in time if we possibly can.

Records and X-Ray Duplication

- All patients are required to provide a current set of x-rays or we will take them. If you wish to have no-x-rays taken at your appointment, please provide us with a current set of bitewing and panoramic x-ray from your previous dentist. X-rays are necessary so the doctor/hygienist can clarify any findings of decay.
- We recommend you have copies made of your x-rays and records if you should choose to leave our practice. We are required by law to keep the originals.
- **I DO/DO NOT consent** to leave detailed messages when confirming my appointments.

If email is requested by either patient or another provider/office, they will not be sent by a secure internet provider. We cannot guarantee encryption.

I understand the above statements.

Signature of patient or guardian: _____

Printed Name: _____

Date: _____