Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group# _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Please turn over & fill out back

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other_____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any cores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐

	Yes	No
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

Notice of Privacy Practices

Harris Parkway Dental Care
6029 Harris Parkway,
Fort Worth, Texas 76132
(817) 423-2223

Name of Privacy Officer: Elizabeth Iverson

Effective Date: 02/25/2021

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical/ dental information. We make a record of the dental care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality dental care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this dental practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical/ dental information. It also describes your rights and our legal obligations with respect to your medical/ dental information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Dental Practice May Use or Disclose Your Health Information

This dental practice collects health information about you and stores it in a chart and/or on a computer and in an electronic health record. This is your dental record. The dental record is the property of this dental practice, but the information in the dental record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical/ dental information about you to provide your dental care. We disclose medical/ dental information to our employees and others who are involved in providing the care you need. For example, we may share your medical/ dental information with other dentists or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical/ dental information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical/ dental information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical/ dental information about you to operate this dental practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your dental plan to authorize services or referrals. We may also use and disclose this information as necessary for dental reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical/ dental information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or dental plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical/ dental information to contact and

child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this dental practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this dental practice, except that this dental practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this dental practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this dental practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region VI - Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Marisa Smith, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**

You will not be penalized in any way for filing a complaint.

remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign-In Sheet. We may use and disclose medical/ dental information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical/ dental information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we may be required make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this dental practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another dentist or dental group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

B. When This Dental Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this dental practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this dental practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical/ dental information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your

Harris Parkway Dental Care

HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights sections describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes/No

May we leave a message on your answering machine at home or on your cell phone? Yes/No

May we discuss your medical condition with any member of your family? Yes/No

If yes, please name the member (s) allowed:

_____
_____

May we discuss anything in your file including account balances, referrals, etc? If yes, please also list ANY limitations or restrictions.

If yes, please name the member (s) allowed:

_____
_____

This consent was signed by: _____

Signature: _____ Date: _____

Harris Parkway Dental Care

6029 Harris Parkway Fort Worth, Texas 76132

Financial Policy

PAYMENT is due at the time of service unless prior arrangements have been made. It is our policy to have a definite agreement between you, the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment, please ask our front desk for an appropriate cost prior to the treatment being performed. For convenience, we accept cash, check, VISA, Master Card, Discover, American Express and Care Credit. All emergency dental services performed without previous financial arrangements with the office manager must be paid for at the time of services rendered.

PATIENTS NOT COVERED BY DENTAL INSURANCE: Payment is expected when services are rendered. If major dental work is required, it is understood that at least half of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. Any dental service performed without previous financial arrangement or verified dental insurance must be paid for at the time of service.

PATIENTS COVERED BY DENTAL INSURANCE: If you have dental insurance, we will be happy to file the necessary forms as a courtesy to you. However, your insurance is a contract between you and your insurance company. You are responsible for your entire bill regardless of what your insurance company pays. We require that you be responsible for your co-payment and deductible at the time of service. After insurance has been filed and if benefits have not been received within 60 days from your insurance company, the entire becomes the patient's responsibility. A refund will be given when the benefits have been received from the insurance company. The office cannot render services in the assumption your charges will be paid by your insuranc4e company. Any balance exceeding 90 days may have a 10% per annum service charge on the unpaid balance. We charge a $10 billing charge for any statement sent 90 days after charges were incurred.

In consideration of the professional service rendered to me or at my request by the doctor, I agree to pay for those services in full. I further agree to pay all cost (s) and reasonable attorney fees if the suit be instituted here under. If your account is turned over to a collection agency and a collection fee of 40% of the account balance will be added and must be paid by the patient. I grant my permission to you to you to telephone me at home or work to discuss matters related to my account. After 2 consecutive missed appointments, it is our policy NOT to reschedule you for any further appointments. There is a $25 charge for all returned checks for which the balance of the check and the returned check fee will be paid for in cash or money order only.

We require 48-hour notice to reschedule or cancel an appointment. This will enable us to serve other patients that may need emergency dental care. There is a $50 charge for a missed or canceled appointment if the 48-hour notice is not given.

As a courtesy to our patients, we offer convenient payment options to help with any out-of-pocket expenses. Please check which options you would be most interested in learning more about. We do have 3rd party financing options.

Please indicate your understanding and acceptance of these financial policies by signing below. It is understood that this executed copy of the Financial Policy will also cover your dependents who are patients.

Printed Name:_____ Date:_____

Patient/Legal Guardian Signature:_____

Harris Parkway Dental Care

Office Cancellation Policy

In order to better serve our patients, we have instituted a cancellation policy. Not showing up for your appointment or canceling your appointment at the last-minute hurts and prevents us from seeing other patients in need.

Please contact our office to confirm your appointment at least 48 hours prior to your appointment.

If you cannot make it to your scheduled appointment, we ask that you contact us 48 hours in advance to cancel or reschedule so we have a chance to schedule another patient who needs to come into our office. We send out notifications by email, text, and/or phone prior to your appointment date and you can contact us by any of those three methods.

We reserve the right to schedule another individual into that time slot if you have not confirmed your appointment.

Not showing up for a scheduled appointment can result in the following cancellation fees:

1st missed appointment – Warning.

2nd missed appointment - $50 Cancellation fee per hour scheduled.

3rd missed appointment – Require a credit card to hold your appointment. $50 will be charged per hour scheduled if this appointment is missed.

If you are more than 10 minutes late for your appointment, we will work to complete as much treatment as possible during your allotted time. Please try to call and let us know if you are going to be more than 10 minutes late.

We realize that emergencies do occur occasionally. If you truly have an emergency which physically prevents you from making your appointment, we will make an exception. Please sign below to show your understanding of our cancellation policy.

Print Name:_____ Date:_____

Signature: _____