



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

Date: _____

MISSED APPOINTMENT POLICY

We are delighted you have chosen Davis and Dingle Family Dentistry to provide you and/or your family's dental care and we want to ensure that you are getting the best care possible. This is why it is so important to keep your scheduled appointments.

Effective December 2016, our missed appointment fee is \$50.00. This fee is not covered by insurance.

A missed appointment is when you fail to show up for a scheduled appointment or when you fail to notify us of the cancellation with less than 48 hours' notice. When you miss your appointment, you compromise your care, and prevent other patients from being seen who are waiting for an open appointment.

The doctor/patient relationship is built on mutual trust and respect. As a courtesy, we make every effort to contact you 2 weeks to 48 hours prior to your scheduled appointment time. We ask that you call (803) 255-0200, and speak with one of our staff members, or send an e-mail to, customerservice@davisanddingle.com.

We appreciate your understanding of the need for this policy.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)

