

Dear Parent,

I am writing to confirm your child/children's initial dental care appointment. Please see the enclosed appointment card. Let me take this opportunity to welcome you to our practice. We take pride in and are committed to providing you quality oral health care in a comfortable, gentle, and professional environment.

Enclosed are the Patient Registration, Medical History and Hipaa (Privacy Policy) related forms. Please complete these forms and bring them to the appointment. **PLEASE INCLUDE CHILD'S SOCIAL SECURITY NUMBER.**

In order to make your child's experience pleasant and efficient, our office policies are as follows:

- **PLEASE BE ON TIME FOR YOUR APPOINTMENT.** If you are late, you risk cancellation of your appointment.
- **PLEASE INFORM US OF ANY CHANGES IN YOUR INSURANCE.** Payment will be due at the time of service if insurance cannot be verified.
- **A 24 HOUR NOTICE IS REQUIRED TO CANCEL OR RESCHEDULE AN APPOINTMENT.** If proper notice is not received it is considered a **BROKEN APPOINTMENT.**
- **A NEW PATIENT BROKEN APPOINTMENT WILL BE CHARGED A ONE TIME RESCHEDULING FEE OF \$50.00.**
- **AN ESTABLISHED PATIENT WITH ONE BROKEN APPOINTMENT WILL BE CHARGED A ONE TIME RESCHEDULING FEE OF \$25.00. IF THE ACCOUNT HAS A SECOND BROKEN APPOINTMENT IT WILL NOT BE RESCHEDULED. DISMISSAL FROM THE PRACTICE WILL RESULT. EMERGENCY TREATMENT ONLY, WITH EMERGENCY FEES WILL APPLY, FOR A PERIOD OF 30 DAYS. THIS WILL ALLOW YOU TIME TO FIND ANOTHER DENTIST.**

We take pride in and are committed to providing your family with quality oral health care in a comfortable, gentle, and professional environment. Should you have any questions about our services, requests, or policies, please contact our office at (864) 234-9800. My staff and I look forward to a relaxed and pleasant visit with you.

Thank you,

Jerry W. Crockett
Business Manager

I have read and understand the above policies.

Signature: _____ **Child's Name:** _____

Date: _____ **Relationship to Child:** _____ **Rev.10/8/07**