**No Show / Cancellation Policy**

*Please Read Carefully*

At Dental Co. of Knoxville, we strive to maintain a high-quality experience for our patients when visiting our office. We do not double book our patients, meaning while you are in our care, you are the only priority. While we understand that emergencies and scheduling conflicts at times can be unavoidable, advance notice of such allows us to better accommodate patients scheduling needs and keeps our office running at the most efficient level. Our office will call you two weeks prior to your appointment as well as two days prior to your appointment when applicable. It is important that you respond to our confirmation call at your earliest convenience.

1. I understand that it is my responsibility to provide the office with 48-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 48-hour notice to modify a scheduled appointment can be responsible for a $50.00 office visit charge. This charge cannot be paid through your insurance and must be paid on or before your next scheduled appointment.
2. I understand that my appointment has been customized to my specific needs. We do not double-book our patients so that we can provide optimal treatment outcomes for all our patients. 48-Hour notice allows us to place another patient in your cancelled appointment period at a more ideal time.
3. I understand that missing regularly rescheduled appointments could prolong or alter my treatment plan. Avoidance of the Doctor's recommendation could lead to infection or more serious problems. In addition, insurance claims might not be processed in a timely manner as most insurance companies do not consider qualifying treatment until completion date.
4. After your second missed appointment without notice, you may be placed on a same day scheduling policy moving forward. This would not allow you to schedule any appointments in advance.

*Thank you for providing our office and our patients with this courtesy.*

*Signing below indicates you understand and agree to the terms of this policy.*

_____ Signature of Patient _____ Date
(Or Responsible Party)

_____ Doctor Signature _____ Date