Cherry Hill Dental Smiles
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Cancellation/ Missed Appointment Policy

Our goal at Cherry Hill Dental Smiles is to provide quality dental care in a timely manner. In order to do so, we have had to implement an appointment/ cancellation policy. This policy enables us to better utilize available appointments for our patients in need of dental care.

Cancellation of an Appointment:

In order to be respectful of the dental needs of other patients, please be courteous and call Cherry Hill Dental Smiles promptly if you are unable to attend your appointment. This time will be reallocated to someone who is in need of treatment that day. If it is necessary to cancel your scheduled appointment, we require at least 48 hours (2 days) in advance. Appointments are high in demand, and your early cancellation will allow another person the opportunity to have access to timely care.

How to Cancel Your Appointment:

To cancel appointments, please call Cherry Hill Dental Smiles at 856-667-3737 at least **48 hours (2 days)** prior to your scheduled appointment. If you do not reach the administration staff, you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and we will return your call as soon as possible. Late cancellations will be considered a **"NO-SHOW".**

NO-SHOW Policy:

A **"NO-SHOW"** is a missed appointment **without 48 hours (2 days) notice**. **"NO-SHOWS"** inconvenience other patients who may need access to dental care in a timely manner. A failure to present at the time of scheduled appointment without adequate notice will be recorded in the patient's chart as a "NO-SHOW" and reported to the patient's dental insurance. There will be a **$25.00 charge and in addition, after three Cancellation/Missed Appointments without adequate notice will result in termination of patient from the practice.** Our office will be available for 30days from time of termination notice to address your dental needs while you seek another dental provider.

I have read the above policy completely. I agree to all the terms and understand that if I violate this policy it may result in the termination of my doctor/ patient relationship.

______________________________ ______________________________

Patient Name (Please Print) **Telephone Number** **Date**

______________________________ ______________________________

Patient Signature **Email Address**