Tosto
FAMILY DENTISTRY
Jason P. Tosto, DMD

# CANCELLATION POLICY

As a family oriented dental practice, we truly take pride in our warm, caring atmosphere. One aspect we really enjoy about our practice is the opportunity to offer quality care and individual attention to each and every one of our patients.

We make every effort to remind our patients through various methods prior to their appointments. Please understand that your appointment time has been reserved especially for you. If that appointment is cancelled shortly before its time, we are missing an opportunity to help another patient that needs care, sometimes even emergency care. We do understand that things come up at the last minute that can't be controlled.

- Cancellation or rescheduling of an appointment with 24 hours or more notification will result in no action.

- A failed appointment is an appointment that is cancelled/rescheduled without 24 hours' notice or an appointment where a patient does not show up.

- After two (2) failed appointments you have two options for scheduling:
    1. You can choose to be placed on "will call" status, which means you may call us the morning of a day that you know you will be available. If the time in our schedule allows, we will have you come in later that day for your appointment. We may also call you if we have an available appointment.
    2. You may schedule an appointment in advance; however, a **non-refundable** reservation fee equal to the appointment fee will be required in order to hold the appropriate time for you.

- After three (3) failed appointments you risk being dismissed from the practice.

For any appointment scheduled for one and a half hours or longer, we will require a 20% **non-refundable** deposit of the total treatment scheduled for that day. If the appointment is canceled or rescheduled within less than 48 hours before the appointment, or the appointment is failed / no-showed, then the deposit will be forfeited.

**ACKNOWLEDGEMENT**

My signature below indicates that I have read, understand and agree to the appointment policy above.

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Printed Name of Patient or Responsible Party

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Signature of Patient or Responsible Party Date