Appointment Management Policy

Patient Appointment Management Policy

Glennhill Family Dentistry is committed to providing our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. We dedicate our valuable time to caring for you, so please try your best to keep your appointment.

Once an appointment is made for you, our office will remind you days ahead by emailing, texting, or calling. You must confirm your appointment with our office when receiving notifications by 2 weeks, prior to your appointment date. Failure to confirm will result in appointment cancellation. We know, however, that emergencies occur, and we try to be understanding when they do. To be fair to all patients, we find it necessary to reinforce our general three-strike policy for missed appointments.

A missed appointment or “No Show” is defined as:

- a) The patient did not show up for their appointment or call to cancel it, or
- b) The patient canceled the appointment too late (less than 24 hours of the appointment) to permit us to fill the time that he/she left vacant.

Our policy on missed appointments is as follows:

1. First missed appointment with less than 24-hour notice - We will offer you an opportunity to reschedule your appointment at a time that is least likely to be missed, forgotten, or interrupted.
2. Second missed appointment with less than 24 hours' notice – Your oral health is important to us, so we will offer an opportunity to reschedule your appointment at a time that is least likely to be missed, forgotten, or interrupted.
3. Third missed appointment with less than 24-hour notice - No further appointments will be scheduled for you, and you will be dismissed from the practice. However, you will be responsible for any outstanding payments due on your patient ledger.

Our office reserves the right to modify this policy on a case-by-case basis. We thank you for your cooperation with our policy. We look forward to continuing to assist you with your oral health needs.

First Name *

Last Name *

Signature

Date

03/29/2023