

Missed Appointment Form

I acknowledge that appointment times are reserved for me. Therefore, I am responsible to inform The Dental Center at least 48 hours in advance to cancel any scheduled appointments for my family or myself. In the event that 48 hours notice is not given, I understand that a missed appointment fee of \$75.00 will be assessed. I also understand that I (not my insurance company) will be financially responsible for this fee.

Signed:_____Date:_____

Witness:_____Date:_____