



BROKEN APPOINTMENT / CANCELLATION POLICY AND CONSENT TO TREATMENT

Welcome to MCDC! We are glad you have made an appointment for yourself or your child for important oral health care. Regular dental visits every 6 months, including examinations, cleanings, fluoride treatments, dental sealants, and fillings are important to keep teeth healthy. It is especially important that you keep your appointment! Valuable time has been reserved for you or your child’s care. A missed appointment results in lost time which could be used for another patient waiting to receive treatment. Below is our “BROKEN APPOINTMENT / LATE CANCELLATION POLICY”.

BROKEN APPOINTMENT / CANCELLATION POLICY

If you fail to show for a scheduled appointment, all future appointments you may have scheduled will be cancelled. If you wish to continue your dental treatment in our office, you must call to schedule a new appointment. We also require 24 hour advanced notice when cancelling an appointment that has been reserved for you. Depending on the nature of the cancellation, any combination of failing to give adequate cancellation notice or not showing for 2 appointments in a 6 month time span will result in **DISMISSAL** from this and all **MCDC/DCN** dental clinics.

EMERGENCY CARE

Dental clients who have been dismissed from the clinic for either broken appointment or cancellation reasons will be notified by certified letter and will be seen for **EMERGENCY** care only for 30 days from the date of the dismissal letter.

CONSENT TO TREATMENT

I hereby give consent to Michigan Community Dental Clinics, Inc. to provide treatment to:

_____, (check one) myself, my child, my ward, those procedures and treatments, including local anesthesia, which are deemed necessary. I consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of the dentist and his/her associates and/or staff members, as he/she may deem necessary.

NOTICE OF PRIVACY

MCDC respects my right to privacy and confidentiality of my personal health information. I acknowledge that I have been informed of, and offered a copy of, the *Notice of Privacy Practices*.

This authorization will remain in effect until canceled in writing by me.

I have read the above policy and agree to abide by it.

_____ Date

_____ Signature of Client (parent or guardian)

_____ Date

_____ Witness