Welcome!!!
Practice Scheduling & Financial Policy

We welcome you to Peace Haven Smiles and are committed to providing you the best treatment possible. Our team is dedicated to ensure that your overall experience with us is successful and pleasurable.
To enable us to best serve all of our patients, please review the following policies. If we focus together on these policies, you will enable us to provide you and other patients with the care that is expected and deserved.

Appointment Policy

When an appointment is established for you, we are reserving the doctor's and staff's time for you to receive the quality of care and treatment that you need. Having ALL patients arrive on time enables us to better serve you and other patients. When you agree to your scheduled appointment, we understand that you are committed as well to arriving on time to help us serve you and others in a more timely fashion.

To help you, our office can send you several reminders prior to your appointment:

- 1-week text message reminder
- 48-hour text message reminder
- A personal phone call to confirm your appointment
- Appointment reminder card

We kindly ask that you **confirm your appointment 48-hours prior to your appointment** with us either by text message response or phone call response. *Please initial* _____

Without confirmation, you may lose your scheduled appointment. *Please initial* _____

Because we take such efforts to prepare for your scheduled appointment, we **greatly appreciate that you notify us at least 48 hours prior to your scheduled appointment time if you must CANCEL OR RESCHEDULE your appointment.** *Please initial* _____

If you are **LATE to your appointment** – there is no guarantee you can be seen that same day. We will do our best to accommodate. We may need to reschedule your appointment if time does not permit to complete your planned treatment. *Please initial* _____

LATE ARRIVAL: we have a 10 minute grace period. Beyond 10 minutes may be considered a broken appointment in which you may incur a fee. *Please initial* _____

Patients who arrive late for their appointed time or cancel appointments with less than two (2) business days notice will incur a $25 broken appointment / late fee and may be charged a non-refundable deposit when scheduling future appointments. *Please initial* _____

In the event of inclement weather, please contact our office prior to arrival if there are any questions as to whether the practice will be open.

Payment Responsibility

All services provided to you, your dependents, or others for whom you are responsible, you will be responsible for payment for said services. Unless insurance is available or payment is otherwise pre-arranged, payment is due in full at the time of treatment. If treatment is terminated or suspended prior to your treatment being completed, any fees for services already provided shall become due and payable immediately. If the account is not paid as agreed upon and is turned over to collections, you agree that an additional fee will be added to your account balance to cover the costs of collection. Returned checks shall incur a $25 return check charge and the patient will no longer be able to pay with a personal check.

You acknowledge that you have read and understand these scheduling and payment policies and agree to them as outlined.

Patient Signature _____ Date _____