



*Specializing in Children, Providing for the Family*

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General and Cosmetic Dentistry for Adults**

### **Appointment Policies**

We are pleased that you have entrusted us with your dental needs. In order to serve you well, it is essential that we develop a working relationship with you that requires your attendance at all scheduled appointments.

Please understand that your scheduled appointment is reserved especially for you. In order to provide each patient with the highest quality of care, we do not double-book patients. Broken or canceled appointments can compromise your dental health and the course of treatment your doctor has planned for you. Last minute cancelations prevent other patients from utilizing the availability and can ultimately add to the cost of providing care for all our patients.

### **Missed appointments**

Missed appointments include:

- Appointments canceled the same day of the appointment.
- No show or broken appointments (appointments that you did not keep and did not call in advance to notify us of your intended absence).

As a courtesy, we will try to contact you to confirm all appointments. However, it is your responsibility to remember and keep scheduled appointments. We kindly ask that you **give a 24 hour notice for cancellation of any appointment**. There is a **\$25 fee** for any missed appointment or an appointment cancelled with less than a 24-hour notice. There is a **\$50 fee** for Saturday and evening appointments that you miss or cancel with less than a 24-hour notice.

### **Late Appointments**

We understand that unexpected delays and emergencies occur. If you are more than 15 minutes late for your appointment, we may ask you to reschedule to allow the full time necessary to complete your treatment and to be courteous to those with appointments after you. You will be billed a \$25 fee for the second late appointment.

**A third subsequent missed or late appointment will require prepayment of the entire fee prior to rescheduling and the fee forfeited if you do not keep the appointment. Patients who habitually reschedule will be asked to seek dental care with another provider.**

Our ultimate goal is to provide all of our patients with the highest level of dental care. We thank you for your anticipated cooperation and look forward to serving you.

Your signature below indicates that you understand and agree to the above policies.

\_\_\_\_\_  
Patient (or patient representative) signature

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date