WEST COBB
DENTAL STUDIO

Removal of Scheduled Dental Appointment

Name: _____ Date of Birth: _____

I understand that the office will attempt to contact me via phone calls and text messages to confirm my scheduled appointment. I acknowledge that it is my responsibility to confirm my appointment and that I must provide at least 24 hours' notice to avoid a cancellation or no-show fee of **$50.00 PER HOUR**

Additionally, I understand that if my appointment is scheduled **FOR A** MONDAY and I **FAIL TO CANCEL IT BY THE PRECEDING THURSDAY**, I will be responsible for a broken appointment fee.

I am also aware that if the office makes three unsuccessful attempts to contact me within a period of **LESS THAN 24** HOURS before my appointment, my appointment will be removed from the schedule. However, I have been informed that **IF THE OFFICE IS ABLE TO FILL** my scheduled time slot, the cancellation fee will be waived.

Signed: _____ Date: _____

Witness: _____ Date: _____