KIDS DENTAL GROUP

Wiley M. Elick, D.D.S., Inc.
833 Greenfield Ave. Ste 105
Hanford, CA 93230
(559)582-3460

Dear Patient,

We strive to provide excellent dental care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for a patient. "No-shows", and late cancellations inconvenience those individuals who need access to dental care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Dental Appointment Cancellation Policy and it is effective immediately.

Our policy is as follows:

1. We request you give our office a 24- hour notice in the event you need to reschedule your appointment. Our phone number is (559) 582-3460.

2. If you miss an appointment and do not contact us with at least a **24 hour** prior notice, we will consider this a missed appointment and a **$40.00** no-show fee with be assessed to you. This applies to late cancellations and “no-shows.”

3. Our office makes reminder calls for appointments. If you are registered for the patient portal, you will receive e-mail reminders as well. ***It is ultimately the patient’s responsibility to remember their scheduled appointments***.

This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you don’t have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.

We thank you for trusting Kids Dental Group with your dental care.

I have read and understand the Dental Appointment Cancellation Policy and agree to the terms of this policy.

____ ______________________

Signature Date

____

Printed Name

KIDS DENTAL GROUP

Wiley M. Elick, D.D.S., Inc.

Parent/Legal Guardian Consent for Dental Treatment

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Child's Name Date of Birth

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Child's Name Date of Birth

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Child's Name Date of Birth

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Child's Name Date of Birth

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Parent/Legal Guardian Name Phone Number

Authorized Caregiver's Information

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Caregiver's Name Home Phone Number Cell Phone Number

The above named caregiver shall be authorized to consent for all dental treatment and dental oral anesthesia, for the above named child(ren), which may be required during my absence. I agree to pay for all services provided to my child(ren) that the caregiver authorized.

If circumstances permit and/or if Kids Dental Group needs to contact me, please contact me at the following telephone number: ____

This consent serves as permission for treatment by Kids Dental Group for the above named child(ren). **The authorization shall be effective until:**

______________________: One (1) year from date signed

OR

Until ___________________ (list Month, Day, Year)

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Kids Dental Group prior to this date.

Signature

____
Parent / Legal Guardian (Circle One) Date

____
Witness Date