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NOTICE OF CANCELLATION POLICY

By my signature below, I hereby acknowledge that I am aware that I must provide Durango Family Dentistry a minimum of **48 hours** notice of cancellation of any appointment made for me or one of my dependents. Failure to do so will subject me to a $50.00 cancellation fee, per occurrence, which I agree to pay within 5 days of receipt of the statement for same.

I also understand that failure to pay the fee and/or 3 or more instances of less than 48 hours notice may result in my dismissal from the practice.

Note: Durango Family Dentistry sets aside time to see you specifically. If you don't keep your appointment or if you don't give us ample time (at least 48 hours) to reschedule someone in your time slot when you are unable to attend, not only is the time slot sitting open, but patients who are in pain who could normally be seen will have to wait.

Print Name: ________________________________

Signature: _________________________________ Date: ___________________

Relationship to Patient: _______________________