Matt St. George DDS
278 E Doyle St
Toccoa, GA 30577

www.toccoafallsdental.com
frontdesk@toccoafallsdental.com
706-886-9439

Cancellation Policy for Dental Appointments

Our goal at Toccoa Falls Family Dental and Implant Center is to provide quality dental care in a timely manner. We do understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 24 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting. We appreciate your understanding and consideration regarding our cancellation and failed appointment policy.

-Cancellation or rescheduling of an appointment with more than24 hours or more notification will result in no charge.
-A failed appointment is an appointment that is canceled/rescheduled without 24 hours' notice or an appointment where a patient does not show up.
-We do allow for one (1) broken appointment as a courtesy.
-Any additional failed appointments will be subject to a fee of $25.00.
-After two (2) failed appointments, we may require a deposit of up to 100% that will be applied to your appointment, in order to reserve any further appointments.
-After three (3) failed appointments, you risk being dismissed from the practice.

To cancel appointments please call 706-886-9439. If you do not reach the receptionist you may leave a detailed message on the voicemail or with our after-hours answering service. You may also cancel your appointment using the confirmation text messaging service, by texting 706-886-9439.

_____
Signature

(over)

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, and the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services

Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complex description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____Date: _____

Signature: _____

Relationship to patient: _____
Dependent family members also covered by this acknowledgement:
_____
_____
_____
_____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:
The patient refused to sign

Communication Barriers

Emergency Situation

Other