Family Health Care Dental Centers

1035 East Wilcox
P.O. Box 746
White Cloud, MI 49349
Phone: 231-689-1608
Fax: 231-689-3162

1615 Michigan Avenue
Baldwin, MI 49304
Phone: 231-745-2736
Fax: 231-745-5050

11 North Maple
Suite 200
P.O. Box 7
Grant, MI 49327
Phone: 231-834-9750
Fax: 231-834-1459

520 Cobb Street
Cadillac, MI 49601
Phone: 231-876-6505
Fax: 231-876-6799

Patient Rights and Responsibilities

Patient Name: _____ Date of Birth: _____

Our mission is to provide quality, integrated and comprehensive health care services that are accessible to all.

Your Rights:

The Family Health Care dental staff is committed to providing quality dental care. You have the right to be informed of the examination findings and to consent or decline the recommended treatment. You have the right to considerate, respectful and confidential care. You have the right to know in advance the cost of the care that you will be provided.

Your Responsibilities:

You must provide the dental staff accurate information before, during and after treatment. It is important that you follow your dentist's advice and recommendations regarding medication, pre/post treatment instructions, referrals to the other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist you may increase the chance of a poor outcome.

We understand that occasionally circumstances arise preventing you from keeping appointments. If you find it impossible to keep an appointment, you should inform us **24 hours** in advance. This will enable us to reschedule an appointment for you and also let another patient have the appointment time that had been reserved for you.

Our policy for failed appointments: (A failed or no-show appointment is considered an appointment that is cancelled less than 24 hours in advance or when a patient does not show up or call at all to cancel a scheduled appointment. Monday appointments should be cancelled the Friday before.)

- The **First** time you fail or no-show for an appointment, you will receive a letter noting that you missed an appointment. You will still be able to schedule another appointment.
- The **Second** time you fail or no-show, we will NO LONGER schedule an appointment for you, but you will be allowed to have same day or next day appointments if there are any cancellations.
- If there is a **Third** no-show we will NO LONGER provide regular dental care for you. We will only offer you emergency treatment.
- If you ask to become an established patient with the dental center and then fail or no-show your **New Patient** exam, no other appointments will be scheduled for you for 1 year. We will only offer you emergency treatment.
- If you are seen on an **Emergency** basis and the doctor would like to schedule you back to continue treatment and you fail or no-show, no future appointments will be scheduled for you for 1 year. We will only offer you emergency treatment.

Thank you in advance for your cooperation.

By signing this form, I am authorizing Family Health Care to provide my dental care, to release my x-rays and other information to my insurance provider, and to bill my insurance. I also am acknowledging that I have read and understand Family Health Care's policy for failed or no-show appointments and accept the consequences if I fail to show up for my appointment.

_____ _____

Signature (Patient, parent or guardian) Date

_____

Witness