Consent/Office Policy Form

Due to the disruptions caused by broken, missed, and/or cancelled appointments with our office, it has become necessary to revise our broken appointment policy effective September 26, 2016.

Please read and initial next to each paragraph.

_____ Please be advised that scheduling an appointment IS YOUR confirmation of the appointment. Not being contacted by our office IS NOT an excusable reason for any missed appointments.

_____ In the event that an emergency arises, please notify our office as soon as possible. However, if this occurs with frequency, we may need to refer your family to another dental provider for future services.

_____ Be sure to arrive to your appointment on time. We respect our patients' time and make every effort to remain on schedule. If you are more than 10 minutes late to your scheduled appointment, your visit may need to be rescheduled. Dr. McAuley will not "rush" to "make up" the time lost.

_____ I understand that an initial and recall dental appointment can include a visual exam of the oral area, a radiographic (x-ray) exam, prophylaxis (cleaning), fluoride treatment, and Oral Hygiene Instruction (OHI) when necessary. I understand that digital photographs will be taken as part of my child's clinical record. I give permission to Dr. McAuley and her team to perform these examinations and procedures on my child at the initial and each subsequent recall appointment. I understand that these services are Dr. McAuley's standard of care and are not based on insurance benefits or coverage frequency.

_____ Electronic Communication Consent:

I agree that this practice may electronically communicate with me through:

☐Email at the following e-mail address:_____

☐Text Message at the following cell phone number:_____

Medicaid/CMS Patients ONLY

_____ I understand that because Florida State Law prohibits Dr. McAuley from charging a broken appointment fee to patients covered by Medicaid/CMS for missed, cancelled, or broken appointments (without 1 FULL business days' notice), an alternate policy must be in place. For patients covered by Medicaid/CMS, more than one broken appointment will result in dismissal from Dr. McAuley's practice.

Consent Statement

By signing below, I acknowledge that I have read and understand the conditions of this agreement. I have been given the opportunity to ask questions and have them answered. My signature below represents my acknowledgement and consent to the statements I have initialed on this form.

_____ _____

Printed name of Parent/Legal Guardian | Relationship to patient

_____ _____

Signature of Parent/Legal Guardian | Date

_____ _____

Team Witness | Date

_____ _____

Dr. Laura McAuley | Date

Revised 09.26.16