

**Gilkerson Family Dentistry  
New Patient Appointment Rescheduling Policy**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Scheduled Appointment Date:** \_\_\_\_\_

**Contact Number:** \_\_\_\_\_

At Gilkerson Family Dentistry, we are committed to providing high-quality care and maintaining an efficient schedule to best serve all of our patients. As part of our scheduling policy:

**New patients who wish to reschedule their initial dental appointment are required to pay a \$150 rescheduling fee.**

This policy helps us ensure that appointment slots are used effectively and allows us to accommodate other patients in need of care.

**Terms & Conditions:**

- The \$150 fee **must be paid in full** before a new appointment can be scheduled.
- The fee is **non-refundable** and does **not apply** toward any future services.
- We require **at least 48 hours' notice** for any rescheduling requests.
- If the appointment is missed without notice or canceled less than 48 hours in advance, **an additional no-show fee may apply.**

By signing below, you acknowledge and agree to the terms of this rescheduling policy.

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**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Staff Witness (if applicable):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Payment Method (circle one):** Cash | Credit | Debit | Other: \_\_\_\_\_

**Amount Paid:** \$150 **Receipt #:** \_\_\_\_\_

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