RURAL HEALTH, Inc.
We specialize in you

No Show Policy

We are committed to provide quality care at Rural Health, Inc.

An appointment is time allotted for you to meet with a provider for needed services.

If you are unable to keep your appointment as scheduled, we ask that you please call at least 24 hours in advance and reschedule or cancel. We realize that emergency situations can arise. If this happens, please call as soon as possible. If you can call ahead and cancel/reschedule your appointment, this can be given to another patient in need of an appointment.

In an effort to provide appointments for all patients that need them and to decrease the number of No Show appointments, Rural Health, Inc. is implementing a No Show Policy. A No Show is defined as a failure to show up for an appointment prior to or within 15 minutes after your scheduled time without calling to cancel or reschedule prior to the appointment time.

No Shows will be documented in your medical record. If you miss three (3) appointments in a row or three (3) appointments in a six (6) month period without calling before the appointment to cancel/reschedule, you may be discharged from Rural Health, Inc. services.

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RURAL HEALTH, INC. DENTAL CLINIC
NO SHOW POLICY

Dear Patient, Parent, or Guardian of:

Our No Show Policy is strict in order to provide good services to patients. If you have an appointment, you must call to confirm or cancel your appointment within 24 hours (one business day) or your appointment may no longer be reserved for you. Appointment cancellations with less than 24 hours (one business day) notice, are considered to be a missed appointment.
Dismissals for continued no shows for new patient appointments will be left to the discretion of the dentist.

For returning patients, the dental clinic will send a letter the first time an appointment is missed without the patient or care giver giving 24 hours notice. For the second missed appointment a warning will be sent. The third missed appointment may result in dismissal from the dental clinic.

Thank you for your cooperation,

Patient Name:_____**DOB:** _____

Signature: _____

Relationship to Patient: _____

Date Signed: _____