Payment and Cancellation Policy

Payment at the time of service is expected. For your convenience, we take cash, check, Care Credit, Credit or Debit cards. The office will be happy to submit claims to your insurance company. I understand that Shelton Dental Excellence will make every effort to collect from my insurance company. I hereby authorize Shelton Dental Excellence to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered covered by insurance for services rendered to me or my dependents.

Please understand that the appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointment times are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs related to staffing and supplies and in order to contain our costs and continue to provide you with affordable fine dentistry for your entire family, we maintain a No-Show/Cancellation Policy for all of our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or is unable to be kept, must be cancelled at least 24 hours in advance of the appointment. Cancellations must be made during normal business hours on work days at least one full business day before the scheduled appointment. Cancellations must be done over the phone by speaking directly to one of our dental professionals. Patients will not be charged if cancellation is made 24 business hours before their appointment.

Since we certainly understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than 24 hours notice, or no notice, a $25 charge will be billed. If a third no-show or same day cancellation occurs, we reserve the right to terminate the doctor-patient relationship as well as another $25 charge.

This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

Signature: _____

Relationship to patient: _____ Date: _____