Cancellation Policy

This letter is to inform you that Florissant Dental Care reserves the right to charge a $25.00 fee for any appointment that is missed or that you failed to cancel within 24 hours.

This time has been reserved exclusively for you and we ask for your cooperation with our policy.

I certify that I have read and understand the above information.

X_____

Signature of patient (or parent/guardian if minor) Date