



Las Vegas Dentistry, LLC
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dentistoflasvegas.com 702-870-3818

Reservations & Cancellation Policy

PLEASE READ THIS POLICY CAREFULLY.

Las Vegas Dentistry LLC is committed to assisting you in order to improve your dental health. We are dedicated to providing you with the highest quality dental care possible by utilizing superior materials and the latest advancements available. In order to do so, you must be committed not only to following your prescribed treatment, but also to showing up for your scheduled reservation.

Our office takes great effort in scheduling a convenient time exclusively reserved for you. It is very important that you show up for your scheduled reservation (appointment) as you have scheduled it. By doing so, you reduce the likelihood of your condition getting worse and you enable us to make the proper arrangements in equipment and materials in order to provide you with the best and timeliest dental treatment possible for the betterment of your oral health.

Las Vegas Dentistry's cancellation and failed reservation policy is as follows:

- If for any reason, should you need to cancel your reservation time, there will be no charge, provided that you give us **48-hours** prior notice.
- If you change or cancel your reserved appointment within 48-hours, you will be charged \$75 (Seventy-five Dollars) for each occurrence. This charge will be billed directly to you.
- In the unlikely event of a Second (2nd) cancellation/failure to show for your reservation. Our office will require a credit card on file in order to schedule you for any other reservation time. Should another cancellation/failed reservation occur, this card will be automatically charged with the outstanding fee(s).

As a dental health provider, Las Vegas Dentistry can only serve you better if you keep your scheduled reservation. We are pleased to help you in any way possible, should you have any questions or concerns, let our team know. Our goal is to ensure that you have an outstanding experience with us.

I, (Print name) _____ have read, understand and accept the above stated terms and conditions.

Signature of Patient, Parent, Guardian, or Personal Representative

Date

* If not signing for yourself: _____
Relation to Patient