Scheduling Policy

Our office has certain guidelines that we feel are essential to the successful and continued treatment of your child. We look forward to providing years of dental care for your child and encourage your cooperation and support.

In order for us to meet the scheduling needs of all of our patients, we ask that you notify our office at least 48 hours before rescheduling or cancelling an appointment. We realize that unexpected things can happen, but ask for your assistance in this regard. You may be asked to seek care elsewhere after two missed appointments.

Please be on time for each appointment. We always try to see each child as close to the appointed time as possible. However, due to emergencies, there may be times that you will need to wait a short while. We ask for your patience during these times. If you have waited more than 15 minutes, please mention it to our receptionists.

As a parent, you know your child best and are a vital member of our team. Your insight will help us to know what will work best for your child in certain situations or circumstances. Parents are welcome and encouraged to accompany their children into our clinical area. In some instances however, a child will feel more in control of their visit if they are on their own. In those cases, we may suggest that a parent wait in the reception area. A member of the team will report back to the parent after the appointment in those instances. Anxiety is not uncommon in children. Initially, a child may exhibit some negative behavior. This is normal but will diminish as we are highly experienced in helping children overcome anxiety. Expect your child to do well and enjoy their visit to our office and it is likely they will.

If you have any questions or concerns, please do not hesitate to ask us. We make a concerted effort to make your visit as enjoyable as possible. Our goal is to provide a great appointment experience with outstanding service. Our doctors and staff maintain the highest standards in pediatric dental care.

I have read and understand the office policies and agree to follow the guidelines discussed above.

Signature: _____ Relationship to Patient: _____

Your Name (please print) :_____ Date: _____

Patient Name: _____ Patient DOB: _____

The laws of Washington State shall govern this agreement. In the event of a lawsuit regarding this agreement, the venue shall be proper only in Spokane County, Washington.