MCDC
MY COMMUNITY DENTAL CENTERS

WELCOME TO MCDC

We are glad you have made an appointment for yourself or your child for important oral health care.

BROKEN APPOINTMENT / CANCELLATION POLICY

Regular dental visits every 6 months, including examinations, cleanings, fluoride treatments, dental sealants, and fillings are important to keep teeth healthy. It is especially important that you keep your appointment! Valuable time has been reserved for you or your child's care. A missed appointment results in lost time which could be used for another patient waiting to receive treatment.

If you fail to show for a scheduled appointment, all future appointments you may have scheduled will be cancelled. If you wish to continue your dental treatment in our office, you must call to schedule a new appointment. We also require 24 hour advanced notice when cancelling an appointment that has been reserved for you. Depending on the nature of the cancellation, any combination of failing to give adequate cancellation notice or not showing for an appointment may result in **DISMISSAL** from **all MCDC** clinics.

If you are referred to another **MCDC** Clinic for specialty services (i.e. pediatric dentistry, oral surgery, or endodontic procedures) and you fail to provide 24 hour advanced notice to cancel that appointment, you will **not** be given another appointment in the office you were referred to.

APPOINTMENT REMINDER

MCDC provides a courtesy reminder approximately two days in advance. Appointment reminders may be sent by voice message, text message, or email. If you fail to keep your scheduled appointment it can result in **DISMISSAL** from **all MCDC** clinics.

MINOR PATIENT APPOINTMENTS

MCDC providers are required to discuss and obtain permission BEFORE providing treatment to all minor (a child under the age of 18) patients. An adult MUST be present in the clinic throughout the duration of the child's appointment. IF a parent is unable to bring the child to the appointment, there is a consent form that can be signed to authorize another adult permission to approve treatment plan procedures. Please request this form in advance of the scheduled appointment.

EMERGENCY CARE

Dental clients who have been dismissed from the clinic for either broken appointment or cancellation reasons will be notified by certified letter and will be seen for **EMERGENCY** care only for 30 days from the date of the dismissal letter.

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SMOKE FREE CAMPUS

In order to maintain a safe and healthy work environment MCDC/DCN is a smoke free campus.
This means that employees, patients and vendors are prohibited from smoking on the grounds or within sight of any MCDC/DCN building. Smoking is defined as the "act of lighting, smoking, or carrying a lighted or smoldering cigar, cigarette, or pipe of any kind."

BEHAVIOR

Seeking and receiving medical care can be stressful and anxiety provoking. For the sake of all individuals involved, civil behavior with proper respect, courtesy and manners must be maintained and observed. There is also a zero tolerance for alcohol, drugs, smoking or weapons on MCDC property. Individuals who use foul language, display threatening or violent behavior, or do not comply with our zero tolerance policy will be immediately dismissed from all MCDC clinics.

It is important to maintain regular 6 month checkup appointments, as well as maintain excellent home care and proper diet. If you **do not** keep on a regular 6 month schedule, maintain excellent home care and proper diet, MCDC **cannot** be held responsible if restorative care fails.
Failure of the restoration due to neglect of oral hygiene and a high sugar/high carbohydrate diet is the responsibility of the patient and not the dentist. Failure of any restoration within a two year time period, and the required follow up repair or extraction will be at the **patient's** expense**.**
I understand and consented to having restorations completed with these guidelines.

NOTICE OF PRIVACY

MCDC respects my right to privacy and confidentiality of my personal health information. I acknowledge that I have been informed of and offered a copy of the *Notice of Privacy Practices.*

CONSENT TO TREATMENT

I HEREBY GIVE CONSENT TO My Community Dental Centers to provide treatment to:

_____, (check one) ☐ myself, ☐ my child ☐ my ward, those procedures and treatments, including local anesthesia, which are deemed necessary, I consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of the dentist and his/her associates and /or staff members, as he/she may deem necessary.

Information about your appointment may be shared with your medical provider.

This authorization will remain in effect until canceled in writing by me.

I have read the above policy and agree to abide by it.