Patient Agreement

Patient Name: _____

Guardian Name (if applicable): _____

To ensure you fully benefit from the treatment planned by your provider and healthcare team, your participation in the following is necessary.

Patient responsibilities:

- You are responsible for making and keeping your scheduled appointment.
- You are responsible for being on time for your scheduled appointment and to contact the KCHD Dental Department if you are running late.
- You are responsible for the cancellation and/or rescheduling of your appointment within 24 hours prior to the appointment.
- You are responsible for calling the clinic to cancel your appointment if you are sick (i.e. fever, cough, running nose, congestion, etc.).
- You are responsible for providing, to the best of your knowledge, accurate, honest and complete information about your medical/dental health history and you are responsible to report changes in your medical status to the dental provider.
- You are responsible for taking an active role in the decisions regarding your oral health treatment plan and care.
- You are responsible for following the recommended preventive health guidelines and home care instructions given by the dental provider.
- You are responsible for treating dental staff with dignity and respect.
- You are responsible for paying any fee associated with your treatment on the day that treatment was rendered.
- You are responsible for maintaining program eligibility annually in order to receive dental services.
- You are responsible for notifying our clerks, within (30) calendar days of any changes in household income, residency, insurance status, and size of your household.

By signing below, I agree that I have read and will abide by this agreement.

Signature: _____ Date: _____