Jessica L. Bishop DDS, PA

6015 Farrington Road Suite 102
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Scheduling Policy

Our goal is to provide quality, individualized care. Due to the customized nature of our practice, appointments are in high demand. We highly recommend making advance reservations for our services. We will always do our best to accommodate your scheduling needs. Our policy enables us to better utilize available appointments for all of our patients. _____ (Initial)

Cancellation of an Appointment

In order to be respectful of the needs of every patient, please call our office promptly if you are unable to make an appointment. No shows and cancellations inconvenience individuals like yourself who appreciate access to treatment in a timely manner, as well as the professional providing the service.

If it is necessary to cancel your scheduled appointment, we require that you call at least 24 business day hours in advance. This courtesy enables us to compensate our employees for their time and maintain a greater availability of our time for you as well as others._____(Initial)

How to Cancel Your Appointment

To cancel appointments, please call 919-489-2793. If you are not able to speak with our staff, you may leave a detailed message on our voicemail or send an email to laurie@jessicabishopdds.com. If you would like to reschedule your appointment, please indicate that in your message. We will return your message and give you the next available appointment time. _____(Initial)

Late Cancellations

A late cancellation is considered when a patient fails to cancel or reschedule their appointment with a 24 hour business day advance notice. Late cancellations are responsible for 50% of the cost of the cancelled appointment.

No Show Policy

A failure to be present at the time of a scheduled appointment will be recorded in your dental record as a “no show”.

- First missed appointment: there will be a charge of 50% of the cost of the appointment billed to your account._____(Initial)

- Second missed appointment: 100% cost of the service fee will be billed to your account. _____(Initial)

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Regarding Insurance and Payments

We do not accept assignment of your insurance benefits. Your insurance policy is a contract between you and your insurance company; we are not part of that contract. As a courtesy, we will file all dental claims for you, provided we have the necessary insurance information. It is the patient's responsibility to notify us of any changes to his/her insurance. Payment is required at the time of service for restorative, orthodontic and esthetic procedures. Preventative procedures (cleanings and periodic exams) are not required to be paid at the time of service, but will be billed after your insurance coverage has paid. The patient will be responsible for any unpaid portion. Please be aware that some, and perhaps all, of the services provided may be deemed non-covered or not medically necessary under dental insurance programs. _____(Initial)

We accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit. Any unpaid balances will accrue interest at a rate of 18% after 90 days. _____(Initial)

I understand and agree to the above.

Patient signature:_____

Date:_____