Scott M. Novak, D.D.S.
Family & Cosmetic Dentistry
505 Kerr Ave.
Denton, MD 21629
410-479-0600
midshoredental.com

Office Policy

Appointments: Your appointment is scheduled specifically for your dental needs. ***A 48 hour notice during business hours*** is required to change or cancel an appointment. We will call in advance to confirm your appointment and we ***require all*** appointments to be confirmed. If your appointment is not confirmed we reserve the right to cancel. A minimum charge of $45.00 will be billed to you and must be paid prior to another appointment being scheduled for appointments missed or canceled without notice. This charge does not fully offset the financial loss or the loss of time which could have been used to treat another patient. Continual missed appointments, late arrivals or cancellations without notice ***will*** result in dismissal from the practice. For contracted dental plans (Maryland Healthy Smiles) in which a charge is not allowed, appointments will not be rescheduled. NO EXCEPTIONS! ***(Initial_____)***

Insurance: Proof of Insurance is required in order to submit dental claims to your insurance company. All co-payments and deductibles are due in full the time of service. ***It is each patient's responsibility to track benefits used.*** Once benefits are exhausted, your plan will not pay for any procedures and you will be responsible for payment. This information can be found on your explanation of dental benefits or by calling the insurance company. ***(Initial_____)***

Payment & Collections: Payment for treatment is due on the date that services are rendered. We accept Cash, Checks, Money Orders, Major Credit Cards & Care Credit. Any amount not covered by your insurance must be paid within 15 days of the statement date. Forms are available for authorizing direct debit from your credit/debit card after insurance has paid. If you "pre-pay" for dental services by credit/debit card and elect not to follow through with the treatment and request a refund, a minimum of 5% will be deducted from the amount you paid to cover the expenses charged by the credit/debit card company. ***(Initial_____)***

Unpaid accounts over 90 days will be referred for collections at a minimum rate of 35% added to the balance owed. Patients are responsible for all collection fees, attorney fees and court costs incurred. Once an account is referred for collections and you choose to continue treatment with our office, your account must be satisfied and treatment will be on a cash basis regardless of insurance status. We will gladly file your claim for reimbursement to you. ***(Initial_____)***

Interest: A rate of 2% (allowed by the State of Maryland) interest will be added monthly to the balance on all accounts over 30 days until the account is satisfied or referred for collections. ***(Initial_____)***

Statement/ Billing Fee: A $5.00 monthly fee will be applied to accounts over 30 days when a statement is generated to cover the administrative costs of copying, mailing, etc. ***(Initial_____)***

Returned Checks*:* Checks returned to us by your financial institution will be subject to a $35.00 fee and legal collection action. ***(Initial_____)***

Records Copying/Transfer Fee: $10.00 per patient. Please allow us 72 hours' notice to process this request for retrieval, preparation and copying of the documents. Originals and previous doctor's records will not be released from the practice and will be maintained in our office per the guidelines of the State of Maryland. ***(Initial_____)***

Consent for Services for Adults*:* All adult patients are financially responsible for their own treatment. If the subscriber of the insurance is anyone other than you, once coverage is verified, insurance will be billed. Please be advised that you, not the policy holder, are financially responsible for balances not paid by the insurance. ***(Initial_____)***

Consent for Services for Minors (Age 18 & under): The parent/guardian accompanying the minor will be financially responsible for all treatment, fees and payment. We will not bill another party for the services. As the responsible party, you are required to provide us with your name, address, date of birth, SS#, employer name and address. If the minor has insurance coverage under another person, the following information will be required: proof of insurance, the subscribers name, address, phone, date of birth, SS# and employer name and address. Once coverage is verified, we will gladly treat the patient. Parent/Guardians must be present with minor patients for all treatment and will be given a pediatric consent form to sign pertaining to treatment being rendered at that appointment. ***(Initial_____)***

Patient Accounts: Patient accounts must be paid in full from previous treatment before beginning new treatment or before the next scheduled routine appointment. This allows us to keep our fees as reasonable as possible and to continue to provide the quality of dental care that our patients deserve. ***(Initial_____)***

I consent to treatment for the patient indicated below, accept financial responsibility for all amounts due arising from the services provided by this office to the patient named below. With requirements and guidelines continually changing, I agree that I may be asked to periodically update my Dental Registration, HIPAA/Consent, Office Policy, etc. ,agree to inform the office of any changes in patients' health history, insurance, address and phone numbers at each appointment and will not hold the office responsible for any errors or omissions that I may have made in the competition of these forms. I agree that this office policy will take place of all previous office policies, may be updated at any time and refusal to complete/sign any of these forms may result in the office refusing to provide treatment.

I have read and understand the above and agree to its content

_____	_____	_____
Patient Name (Please Print)	Patient Signature (parent/guardian of minor)	Date

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Consent for Treatment and for Use and Disclosure of Health Information & Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____ DOB :_____

Full Address:_____

Telephone :_____ E-Mail:_____SS#:_____

TO THE PATIENT- Please read the following statement carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent.

We reserve the right to change our privacy practices as described on our Notice of Privacy Practices. If we change our policy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I give Dr. Novak's office permission to contact me via text message, e-mail and telephone. I agree to immediately alert the office to any changes to my phone numbers and/or email address. This communication includes, but is not limited to: Receive text message and/or email appointment reminders, confirm your appointment via e-mail or/or text message, request appointments via email, e-mail or text message correspondence (including but not limited to treatment notes, x-rays, etc.) to any referring specialist, receive and respond to our patient satisfaction surveys.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Obtaining a Notice:
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: HIPAA Compliance Officer
Address: 505 Kerr Ave, Denton, MD 21629 Phone: 410-479-0600

I have had full opportunity to read and consider the contents of this Consent form and have read and received your Notice of Privacy Practices.

Signature:_____Date:_____
(Patient, Personal Representative, or Parent/Guardian for Minor)

For Office Use Only

Attempt was made to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
____Individual refused to sign
____Communications barriers prohibited obtaining the acknowledgement.
____An emergency situation prevented us from obtaining acknowledgement.
____Other (Please specify)