MODERN FAMILY DENTISTRY
Andrew T. Wilson, DMD
3195 Cold Springs Road
Huntingdon, PA 16652
www.amodernfamilydentist.com
814-643-7300

OFFICE POLICIES AND PROCEDURES

We would like to thank you for the trust and confidence you have shown by selecting our office to provide dental care for you and your family. Please read through our office policies & procedures and let us know if you have any questions at all.

CONSULTATION CARE

All new patients are initially scheduled for either a comprehensive or emergency examination. Patients experiencing pain or a specific dental problem will be scheduled as an emergency and billed accordingly. New patients seeking routine dental care will be scheduled for a comprehensive examination. This examination will allow Dr. Wilson to review your medical history, take and/or review any necessary x-rays, and discuss any concerns in order to evaluate the course of treatment specific to your dental needs. You will be responsible for the total fees at the time of your appointment unless insurance benefits are available.

EMERGENCY CARE

Emergency patients will be seen as soon as the schedule permits. Emergency patients will be charged for an emergency examination and any necessary x-rays. Payment is required at the time of service, unless insurance benefits are available. Any additional fees will be discussed prior to treatment.

SCHEDULING APPOINTMENTS

When scheduling an appointment that involves a treatment plan totaling $500 or more or consists of 1 ½ hours or more of a time period, we will ask for a 20% deposit of the total cost of the appointment being scheduled. We ask for this deposit the day you schedule your appointment which will secure the time for you and shows your commitment to our office for your treatment. This deposit is part of the fee and not an additional charge. If you would cancel or fail the appointment the fee is non-refundable.

MISSED APPOINTMENTS

When you schedule an appointment with Dr. Wilson for dental care, the time is reserved especially for you. As a courtesy to our office and our scheduled patients, Dr. Wilson requires 48 hours' notice if you need to change or cancel an appointment. Some exceptions will be permitted. *If you fail to notify us of a change or cancellation, a fee in the amount of $75.00 will be charged to your account for the first broken appointment and $90.00 will be charged for each subsequent broken appointment.* Arriving late by fifteen minutes or more for any appointment will also be considered a broken appointment. Multiple broken appointments may result in patient dismissal. The time allotted for you could be used to provide and effectively schedule needed dental care for other patients.

TRANSFER OF RECORDS & RADIOGRAPHS (X-RAYS)

If there is a need to transfer records or radiographs (x-rays) out of our office, a written release form is necessary and required in order to process your request. There is a fee of $10.00 per family to copy records. ***Any outstanding balances will need to be paid in full prior to releasing any records.*** Your request will be honored within a thirty (30) day period, as allowed by Pennsylvania State Law.

DENTAL PROCEDURE INFORMATION

When dental procedures such as preventative care (exams and cleanings), restorative (fillings), prosthetic (crowns and bridgework), periodontal (scaling and root planning), and endodontic (root canal treatment) are being rendered, Dr. Wilson will make every effort to assure you that your visits are pleasant and comfortable. There may be instances, however, when some discomfort or pain may be present. The following is a partial list of procedures that could cause discomfort after a dental appointment:

1. Administration of local anesthetic (soreness in the area of injection)
2. Restorative and Prosthetic procedures (teeth may be sensitive for 3-14 days after the procedure is completed)
3. Root Canal Therapy (some discomfort may be experienced for up to 24 hours after the appointment)

Please be advised that if you experience discomfort after your dental procedures, you should call our office immediately for evaluation and instructions. It may be possible that Dr. Wilson will need to examine you or refer you to a dental specialist for further evaluation and treatment.

SPECIAL CARE FOR CHILDREN

For your child's welfare, insurance regulations do not permit children to be in the treatment room when dental procedures are being performed, if they are not receiving care. Children are not to be left unattended in our office or reception area.

Our practice welcomes children as dental patients. We kindly ask that parent or legal guardian wait in the waiting area during routine "check-up" visits (examinations and cleanings). When restorative dentistry (i.e. filling) is necessary, we request that the parent or legal guardian kindly remain in the waiting area. This is to allow Dr. Wilson and the dental assistant to have the full attention of the child and provide dental care in a conducive manner. If your child is under the age of 18, has a dental appointment, and you are unable to come with them, we would need a written note giving permission to complete treatment on your child for that scheduled appointment.

Performing dental procedures requires the child to maintain an open mouth and to keep their head still. For some children, this may be difficult. In some situations, Dr. Wilson may recommend that a pediatric dentist complete the dental treatment to assure that your child receives the care necessary in a comfortable and pleasant environment. Dr. Wilson will determine if this type of referral is necessary for the welfare of your child.

FINANCIAL & INSURANCE INFORMATION

Just as we are committed to providing you with quality dental care, we are also concerned with keeping our fees for service reasonable. One way we can accomplish this is by eliminating costly billing procedures and requesting payment at the time of your visit. We understand there may be special reasons or situations that arise and cause difficulty for some of our patients to pay at the time services are rendered. Please help us by informing our staff in advance. A fee of $20.00 will be attached to each statement that needs mailed for an outstanding balance. If you have insurance benefits, your **estimated** copayment will be collected in full at the time of service and the claim will be submitted for payment. Once the claim is paid, one statement will be mailed for any remaining balance. We ask that you pay this balance in full within 30 days to avoid any additional statements and fees. For your convenience, we accept payment by cash, check, debit cards, money orders, and credit cards including: Visa, MasterCard, Discover, and American Express. There will be a $25.00 charge for any returned checks. Interest free financing is also available through Care Credit and Wells Fargo for treatment over $1,000.00.

INSURANCE POLICIES:

If you have dental insurance benefits, our staff will submit your dental claims to your primary insurance carrier. We will accept assignment of your dental benefits (If your insurance will be sent directly to our office). Delta Dental and United Concordia, however, will only send reimbursement to the patient, *so payment is expected the day of service.* You are responsible for any deductibles, co-payments, or payment of non-covered services at the time treatment is completed. You will also receive a courtesy monthly statement with any remaining balances after your insurance carrier has made payment in full. **A finance charge will be added to any overdue balances after 30 days.** (This includes balances after the insurance payments have been made) along with the $20.00 additional statement fee.

A dental plan is merely a contract between the employer and the insurance company to aid or partially pay for certain services. There are deductibles. Some services are paid on a percentage, while others may not be covered at all. ***You are responsible for knowing what your dental coverage includes.*** It is not our responsibility to know your benefits, but we can assist you in finding out this information. Any questions you may have regarding your coverage need to be answered *prior* to your appointment date. Your employer purchases a contract at a specific premium which includes as many or as few benefits as the employer will allow at a certain "usual and customary" fee schedule. Our fees are established by the actual cost of doing business in this particular office. Obviously, costs may vary between different offices depending on the quality of service, materials used, lab costs, and many other factors. Our diagnostic equipment, sterilization procedures, and restorative techniques are state-of-the-art. Our fees reflect the quality of service and care delivered by Dr. Wilson and staff.

Thank you for choosing our office for your dental care and we look forward to getting to know you. Please don't hesitate to ask us any questions.

I have read, understand, and consent to Modern Family Dentistry's office policies and procedures and I am also aware of my financial obligations. **I, therefore, agree to pay my portion due at the time of service unless other arrangements are made in advance with the business office and/or office manager.**

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Signature of Patient and/or Responsible Party Date

______________________________ ______________

Emergency Contact Person Phone Number

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Relationship

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Authorization for Use or Disclosure of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by this practice. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for social media and/or advertising.

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:

○ "Yes, I would like a copy of this form."
(initialed by team member, copy provided by __________)

______________________ ______________

Patient Name Date

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Signature of Patient and/or Responsible Party