NOTICE OF OFFICE POLICIES

Mercersburg Family Dentistry
200 Loudon Road, Mercersburg, Pa 17236
717-328-5700

Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when paying your responsible portion in a timely manner. We cooperate fully with our patients who are covered by the insurance plans we participate in. Mercersburg Family Dentistry assumes no responsibility should the patient err in the utilization of their insurance. It is the patient's responsibility to provide their complete insurance information, including the card for us to make a copy front and back to have on file. It is important for you to understand that in most cases, insurance is designed to reduce your costs, not eliminate it completely. The office personnel can give you an estimate of the portion that will not be covered and you will be responsible for paying this at the time of service. We submit the claim to the insurance company to pay their portion. If there is still a balance due, you will be responsible for this, and a statement will be sent. IF your insurance company has not paid the claim in 90 days, the full balance will be come your responsibility.
If your account becomes outstanding for more than 90 days, you will be sent a warning to bring it current within 10 days. After that it will be turned over to collections and additional fees may be added.
Any check returned to our office for insufficient funds will be subject to a $50 return check fee. Immediate remittance of payment is then expected in the form of cash, certified funds, or credit card.
If you are unable to keep your scheduled appointment, 24-hour notice is required. Otherwise, after the second occurrence, you may be charged a $50 fee and dismissed from the practice.

If at any time you have any questions about this policy, your account or our practice, please do not hesitate to contact our office at 717-328-5700.

I have read the above policy and agree to accept.

____

Signature of patient/guardian   Date

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

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200 Loudon Road, Mercersburg Pa 17236
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Information to be Used or Disclosed
The information covered by this authorization includes Health Insurance, and Billing Information. Treatment, Payment, and Healthcare operations.

Purpose of the Disclosure by signing this form, you will consent to our use and disclosure of your personal information to treat, diagnose and bill.

Persons Authorized to Use or Disclose Information: MERCERSBURG FAMILY DENTISTRY.

Please list other Persons to Whom Information May Be Disclosed/released to:________________________

Expiration Date of Authorization
This authorization is effective through (check one)☐ _____/_____/_____ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

(Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.)

Name of patient (Print) Date

Signature of Patient Relationship to patient (if applicable)

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