glen ellyn
DENTISTRY

CHARISE M. PETRELLI, DDS

Office Policies

Appointment Times: Please remember your appointment has been reserved for you. Confirmation reminder emails and text messages are a courtesy. We ask that you provide at least a 24-hour notice to change or cancel your appointment. If the office is closed, our answering machine is always available for you to leave a message.

Broken Appointments: An appointment that the patient does not show for, is more than 20 minutes late for, or calls less than 24 hours prior to the appointment time to cancel will be considered "broken" and **will be charged $50.00 per hour** after the first occurrence. We reserve the right to dismiss patients from our practice after continuous broken appointments.

Financial: I agree to be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of service, regardless if I have insurance. In some cases, your insurance will be billed prior to you receiving a statement in the mail explaining your balance. In the event payments are not received by agreed upon dates, the practice may refer my unpaid balance to a collection agency. I understand that I will be responsible for any and all fees and expenses, such as attorney fees, related to the collection of any unpaid balance.

Returned Checks: All checks returned to us by your bank for Non-Sufficient Funds will result in a charge of **$30.00** and is due immediately including the amount of your check. After the first returned check, payments will then need to be made by cash, credit or debit card, money order, certified check or Care Credit.

Insurance: As a courtesy, we will file your insurance and we will verify your insurance eligibility. This does not guarantee payment of your benefit but only tells us that you are eligible today. If anything changes in the future, your benefits may be reduced or denied. Please notify us of any changes to your insurance. We will estimate your benefits but if payments are ever denied or the company fails to pay its portion, you are responsible for the entire fee.

If you have both primary and secondary insurance, we will submit all necessary paperwork to the secondary insurance following payment from the primary. This process may sometimes take up to several months. Please make us aware if you will be using a Flexible Savings or Health Savings Account so that we may help you maximize your benefits.

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received, read, and reviewed a copy of the Office Policies

Patient Name: _____ Date: _____/_____/_____

Signature: _____ Relationship to Patient: _____

www.glenellyndentistry.com

577 Pennsylvania Avenue, Suite 100, Glen Ellyn, IL 60137

P 630.942.0727 F 630.942.0136

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DENTISTRY

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Notice of Privacy Practices (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e. your endodontist, oral surgeon, etc.) in connection with our rendering dental treatment to you (i.e. to determine the results of root canals, surgery, etc.)
- To third-party payors or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, dates of payment, etc.)
- To certifying, licensing and accrediting bodies (i.e. state dental boards, etc.) in connection with obtaining certification, licensure or accreditation
- Internally, to all staff members who have any role in your treatment
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment
- To contact you in order to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you
- To email your x-rays, photos, and treatment plan to your other doctors as needed
- To leave messages and/or email you regarding upcoming appointments

Any other uses or disclosures of your protected health information will be made only after obtaining written authorization, which you have the right to revoke. Your rights regarding your health information:

- You may ask us to communicate with you in a confidential manner, ask to see or obtain photocopies of your health information and/or ask us to amend your health information if you feel that it is inaccurate or incomplete.
- I give permission for me or my child's photo to be displayed in this office or to be used on facebook or our website.

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received, read, and reviewed a copy of the Notice of Privacy Practices (HIPAA).
I authorize use of my signature on and release of information for insurance claim submissions.

Patient Name: _____ Date: ____/____/____

Signature: _____ Relationship to Patient: _____

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