**MICHAEL J. HATRAK, D.M.D., P.A.**
*General & Cosmetic Dentistry*

313 Broad Street
P.O. Box 318
Florence, NJ 08518
Tel: (609) 499-3800
Fax: (609) 499-5073
www.florencenjsmiles.com

Family Care

# WELCOME TO OUR OFFICE!

## OPEN FOR YOUR CONVIENCE ON:

**Monday 8 am – 7 pm; Tuesday 8 am – 5 pm; Thursday 8 am – 7 pm & Friday By Appointment**
**Alternate Saturday's 8 am – 1 pm** (Saturdays **unavailable** June to Sept.)

## NEW PATIENTS

Thank you for choosing us! The most valuable service we have to offer is a thorough and complete diagnosis. It is helpful to bring a list of any current medications as you will be asked to complete a medical history.

## INSURANCE PLANS & PAYMENT

Our office is happy to assist you with your insurance claims and processing and will give an estimate prior to services of your financial obligation according to your specific insurance plan. For any services in which a coinsurance is involved, payment is expected at time of service. We thank our clients for their consideration in regard to the above financial policy.

We accept various forms of payment including but not limited to; ***Cash, Check, Visa, MasterCard, Discover, and American Express,*** as well as a third party payment option through ***Care Credit***, please ask for details.

We never want financial investment to keep you from optimal oral health and hope you feel comfortable coming to us so we can work towards this common goal.

## EMERGENCY VISITS

Your discomfort is our immediate concern. In the case of any emergency, no matter how small, call immediately and we shall arrange for you to be seen as soon as possible. After hours emergency care is available. Information is provided to you after hours through our answering service.

## APPOINTMENT TIME CONTROL

We respect our patients' time and make every effort to remain on schedule. We also try to complete treatment in as few visits as possible. We strive to be considerate to our patients' time and have found that they are likewise, considerate of our time. We do require two (2) business days notice if an appointment time must be changed in order to avoid a missed appointment fee. We have other patients who need to make appointments and this gives us time to contact them. With insufficient notice people who want to see us cannot be accommodated.

*Thank you,*
*Dr. Hatrak and Staff*

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## Plan of Care Policy

I, _____, voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids unless I give my signed revocation. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

## Financial Policy

I understand and acknowledge that I am fully and completely responsible for the payments of co-pays and co-insurance payments associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist, are estimated and due at the time services are rendered. As a courtesy to me, the dental office will bill my insurance company for their portion of payment for my services, I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. If the insurance company plan fails for ANY reason to reimburse the dentist within 30 days after being billed, I will remain liable for any and all amounts left unpaid. I acknowledge that it is my responsibility to provide the dentist with my current insurance information and any changes thereto.

All returned checks will be subject to a $25.00 returned check fee. Any account balances that remain unpaid for 90 days from the date of service may be referred to a collection company or attorney. In the event this occurs, I agree to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

**Patient:** _____ **Date:** _____

**Print Name:** _____

**Guardian/Responsible Party, if minor:** _____ **Date:** _____

**Print Name:** _____

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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**Name:** _____
**Date of Birth:**_____

### TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS 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 encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy 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.

**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 above. Please understand that revocation of this 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.

### SIGNATURES

**I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.**

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

### EMAILING X-RAYS

**In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.**

**I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.**

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed**