OFFICE POLICIES

Dear Patient,

We are extremely happy, you have chosen the office of Dr. Kelly Hollis DDS PC to care for your oral health. We would like to take this opportunity, to inform you of your responsibilities, and our office policies, regarding insurance payments, failed appointments and billing. This will avoid any misunderstandings, and allow us to serve you better.

1. As a courtesy to our patients, we will process your insurance claim; however, dental insurance rarely covers the total cost of treatment. Your **co-payment** is due at or prior to the time of treatment.
   Your Co- payment is the estimated amount not covered by your insurance.
2. We understand that emergencies, arise from time to time, and appointments might be unavoidably missed. We will not charge you for the first missed appointment, but the second failed appointment, or appointment cancelled without **48 hours' notice**, will incur a fee of **$50.00.** This fee is not payable by insurance and will be the responsibility of the patient.
3. We will make an effort to remind you, of your appointment by phone, two days prior to your appointment. Please note, this is a courtesy call, and we cannot guarantee you will receive a call. If it becomes necessary for you to cancel or change your appointment, we **do** request a **48 hours' notice.** We require, that you notify this office at least **48 hours** in advance to avoid a failed appointment fee.

Kindly acknowledge your agreement with these policies by signing below and bring this form with you to your next visit. If you have any questions, please call us at 717-292-6548 or ask our front desk staff at your next visit.

Thank-you, we look forward to serving you.

Patient Signature: _____ Date: _____

PATIENT CONSENT AND RELEASE FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health and dental information. I understand that this information can and will be used:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment.

Obtain payment from third party payers. (Insurance Co.)

Conduct normal healthcare operations such as quality assessments.

Allow our office to release patient records to schools, Insurance Companies, and any other healthcare providers.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my dental information prior to signing this consent. I understand that this office, Kelly Hollis,D.D.S.,P.C has the right to change the Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing how my information is used or disclosed to carry out treatment and payment. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____