ST. FRANCISVILLE
FAMILY DENTISTRY

C. Brent Wilson, D.D.S.

Scheduling Policy

- In order that we do not keep you waiting, we reserve your appointment time for only you, and we do not double-book appointments. This allows us to see you on time and avoid wasting your time. **Forty-eight (48) hours notice is required if you need to change an appointment – failure to do so may result in termination from clinic**. There may be a charge for cancellation without adequate notice, except in the case of a medical emergency. A legal guardian should always accompany minors, unless prior agreement has been established. For unaccompanied minors, treatment can be denied.

Financial Policy

- **Payment is due when services are rendered**. Master Card, Visa, personal checks, or cash may be used for any payment. If your insurance company has not paid your account in full within 45 days, we will expect the responsible party to pay the balance.
- We will be happy to assist you in filing your insurance claim, although you are ultimately responsible for your bill. We will file your insurance form for you after you have supplied us with the required information. This form must be signed to allow us to release the necessary information and allow the insurance company to mail payments to our office. If you would like to use your insurance to assist you in paying for your treatment, you must pay your portion of the bill prior to treatment.

Privacy Practices

- I understand that my healthcare information concerning my diagnosis, treatment, payment, and insurance will be disclosed when necessary for filing my insurance, in communicating with other health professionals in the course of my treatment at their offices. Limited information will also be disclosed to businesses supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support, billing personnel, answering services, and consultants. These businesses are restricted in the use and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that family member or person.
- I understand that my files are stored on shelves and computers in the business office. Only staff and janitorial personnel may have access to this office during non business hours. This office will make every effort to keep your information secure and correct any violation of your privacy if this should occur.
- I understand that I have the right to access, copy or inspect and correct my healthcare information, the right to restrict disclosures and obtain an accounting of disclosures, and to voice my concerns to the practice and/or the Secretary of Health and Human Services within 180 days of my discovery of a problem or a breach or violation of disclosure without fear of retaliatory acts by this office. Any correction to my records would be in the form of a note or letter signed by me. I also have the right to revoke my consent or authorization for disclosure. (A minimal fee (.20/page) may be charged to copy your records for you).
- I understand that I will receive communication in the form of phone calls and postcards to remind me of an existing appointment, time to schedule an appointment or mail containing financial information, such as ledgers or bills. Communication may also be sent to me in the forms of fax or e-mails or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my **personal** home or work voice mail.

I have read and understand this office policy. I understand that by signing this agreement, I give my permission to use and disclose my personal and health information to carry out treatment, payment activities, and health care operations. This office retains the right to revise the privacy policy.

I grant authority to Dr. Brent Wilson to administer necessary anesthetics and to perform any dental procedures deemed necessary in the diagnosis and treatment of my case.

_____ _____

Signature Date

☐ I have read this form and do **not** wish to sign.

_____ (Please initial)