MIDWEST DENTAL CENTER
A.J. SALERNO, D.D.S.

9007 W. CERMAK
NORTH RIVERSIDE, IL 60546
Telephone: (708) 447-8422
Fax: (708) 447-8494

Office Policy

FOR PATIENTS WITH INSURANCE: As A courtesy to you, it is our policy to bill your insurance carrier; keeping in mind that the whole responsibility of the bill rest with you. We require that your estimated co-pay amount not covered by insurance be paid at the time of each appointment. If your insurance company does pay in 30 days, the remaining balance becomes due by you.

FOR PATIENTS WITHOUT INSURANCE: All balances are due and payable in full at the time of service. At your consultation appointment, we will give you an estimate of what the treatment will cost. We will be glad to offer you a treatment plan option that can help your needs. As another alternative, we can spread your treatment out to help pay as you go. If your balance is paid in full before treatment begins, bookkeepers courtesy of 5% will be extended to you.

OUR OFFICE POLICY FOR ANY MISSED APPOINTMENT: If you are unable to attend your appointment we ask that you call our office in advance **24 hours** prior to your appointment to reschedule. Our time is as valuable as yours. This will give us time to add patients to our schedule who are seeking a sooner appointment. Without a **24 hour** notice there will be a 20% charge to your account for any missed or broken appointment. All minors (17 yrs. and under) must be accompanied by an adult. There is a fee for copies and transfer of patient records.

Midwest Dental Center
Dr. A. J. Salerno

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____

MIDWEST DENTAL CENTER
A.J. SALERNO, D.D.S.

9007 W. CERMAK
NORTH RIVERSIDE, IL 60546
Telephone: (708) 447-8422
Fax: (708) 447-8494
Email: dr.ajsalerno@sbcglobal.net

Patient Consent Form

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. 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 action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____