Cetronia Dental Associates

3640 Broadway • Allentown, PA 18104 • 610-395-0500

On behalf of Dr. Gearhart, Dr. Shucavage and the entire staff of Cetronia Dental we would like to welcome you to our practice. Our office has been maintaining healthy smiles in the Lehigh Valley for over 50 years. We strive to provide the highest level of quality dental care and are devoted to making your appointments as pleasant and comfortable as possible. We appreciate you entrusting us with your oral health and look forward to treating you and your family for many years to come.

FINANCIAL POLICY

Our office will make every effort to ensure your dental care is affordable. All dental insurance information should be brought to your appointment so we can properly submit claims on your behalf to receive the maximum benefit to which you are entitled. Any remaining balance after your insurance payment or if your maximum is reached is the patient's responsibility. Prompt remittance is appreciated. If there is no dental insurance, payment for services is expected to be paid in full at the time of your appointment. For your convenience, payments are accepted in cash, personal check or credit card including Visa, MasterCard or Discover. We are able to make arrangements for a monthly payment plan for more extensive services which accrue large balances. The payment schedule must be discussed in advance and will be accompanied by a treatment plan that the patient will sign prior to work being completed.

CANCELLATION POLICY

You will receive a confirmation phone call approximately 48 hours prior to your appointment. We will leave a message if you are unable to answer. It is important for our office to maintain up to date information, including best contact number for confirmation purposes. Please notify us of any change to your phone number, insurance information or address so we can better serve your needs. Every patient is carefully scheduled in order to allow the necessary time to complete their treatment and to provide the quality experience and care we are proud to offer. Your appointment time has been reserved specifically for you. Therefore, we ask for a minimum of 24 hours notice if your appointment needs to be changed or cancelled. In the event notice is not given or if you do not arrive for your appointment, after the second time, a broken appointment fee will be billed to you. It is our wish to never have to charge a patient for broken appointments.

Signature ____ Date __________________

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

•We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

•We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

•You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare; but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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Acknowledgement of Receipt of Notice of Privacy Practices

You may Refuse to Sign This Acknowledgement

I, ____, have received a copy of this Office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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