Dr. Mitchell Brudno DMD
1021 Marlton Pike West
Cherry Hill NJ 08002
8546-42-4249

OFFICE POLICY

We appreciate your allowing us to provide dental care for you and your family. Because we value our relationship with you and believe that the best relationships are those based on understanding, we offer these clarifications regarding our office policies.

We accept cash, checks, money orders, debit and credit cards (Visa, Mastercard, Discover, American Express and Care Credit) as payment to your account.

You are responsible for all charges at each visit. If you have dental insurance, we will file the claim as a courtesy on your behalf. Some insurance companies will pay us while others will pay you directly. If your insurance company pays us, your co-payment and any portion the insurance does not pay is due before the beginning of treatment. Although we make every effort to estimate your payment and ensure we maximize your insurance benefits, you are responsible to pay immediately any balance not paid by your insurance for any reason.

Please come prepared to pay at every appointment. If you are not prepared to meet your financial responsibility at the time of your visit, we reserve the right to reschedule your appointment and a late cancellation fee may be charged. Also late charges may be incurred due to billing multiple cycles as monthly statements are sent out.

If your insurance company has not paid your account in full within 45 days, the balance will automatically be your responsibility unless other arrangements have been made. If your account becomes 90 days overdue, your account will be sent to our collection agency and all fees associated with collection of the overdue account will be charged to you.

48 hours notice is required for appointment cancellations. If the appointment time is missed and our office has not been previously notified there may be a $60 charge to your account. Please help us to serve you better by keeping your scheduled appointments.

If you have any questions regarding our office policies please feel free to ask.

I have read and understand the above Office Policy.

PRINT NAME_____ Date: _____

SIGNATURE_____

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Signature On File Designation

Your signature permits our office to submit insurance information to your insurance carrier for procedures performed at this office for yourself and other family members covered under your insurance policy, and to permit assignment of benefits to this office. Please sign below to give permission to utilize a signature on file designation to submit insurance forms to your carrier on your behalf.

Signature of Insured Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Mitchell Brudno DMD LLC, and of your individual rights and Mitchell Brudno DMD LLC's legal duties with respect to confidential information.

Ways in which I may use and disclose your protected Health information:

I may use and disclose at my discretion your medical records for each of the following purposes only: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing mental health care and related services.
- **Payment** means activities such as obtaining payment for the mental health care services I provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care. I will use and disclose your protected health information when required by federal, state or local law. Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing a I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family? If YES, please name the members allowed:	YES	NO

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Please sign to indicate you understand my operation use of your information for treatment, payment and health care operations as stated above.

_____ _____ _____

Patient Signature Witness Date