

McLellan Dental Inc. Practice Information

1100-2 S. Ponce de Leon Blvd.

St. Augustine, FL 32084

Phone: 904-829-6321 Fax: 904-829-2338

Matt McLellan D.M.D.

Carlos J. Santiago D.D.S.

Welcome to our practice of family dentistry.

Our goal is to provide quality dental care in a professional and friendly manner.

Our office strives to accommodate dental emergencies as soon as possible.

Our doctors can be reached by cell phone, after hours, for patients of record.

The number is provided on the office phone message.

Please allow 48 hours for prescription refills.

7-10 business days are needed for X-ray and record duplication.

CHARGES WILL APPLY.

**We ask that you give 48-hour notice if you need to cancel an appointment;
this allows us to fill the time we had reserved for you.**

FINANCIAL POLICY

- Payment is expected at time of service. This includes co-pays, co-insurances and deductibles.
- At check-in, our staff will ask you for payment of any past-due balances as well as your portion of the payment for today's services. Failure to meet your financial obligations could result in being dismissed from the practice.
- If you are unable to keep your scheduled appointment and fail to give 48-hours notice of cancellation, you may be charged a \$60 broken appointment fee.
- Patients who do not show up for a scheduled appointment three (3) times within a 12-month period, and fail to notify us prior to the appointment, will be discharged as a patient.

Signature: _____ Date: _____

Privacy Practices Acknowledgement Notice

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

- Conduct, plan and direct treatment and follow-up among 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 dental certifications.

I have read, received and understand your *Notice of Privacy Practices*. 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 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this *Notice of Privacy Practices*, but was unable to do so as documented below:

Date _____ Initials _____

Reason _____

McLellan Dental, Inc.

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FINANCIAL CONSENT

I authorize the release of information, including notes necessary to process this claim. I also authorize my insurance company to make payments for these services to MCLELLAN DENTAL INC.

PAYMENT FOR SERVICES EXPECTED AT THE TIME OF SERVICE

Method of Payment: Cash ___ Check ___ Credit Card ___ Insurance ___

ANY MISSED APPOINTMENTS WITHOUT 48-HOUR NOTICE WILL BE CHARGED AT THE RATE OF \$60 (NO INSURANCE APPLIES).

I agree with the statements above and verify they are truthful and accurate.

Signature: _____ Date: _____

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It is a policy of our office to inform you of your financial obligation. In order to avoid an accumulating balance, our office requires that you make payments at the time services are rendered.

It is important to be aware that any disputes over coverage must be handled between you and your insurance company.

Please sign below to indicate your agreement to this financial consent:

Client/Patient or Guardian Name: _____
(please print)

Signature: _____ Date: _____

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By disclosing my credit card information and signing below I hereby authorize MCLELLAN DENTAL INC. to automatically debit my credit card for any account balances outstanding by more than 60 days.

Credit Card Type: Mastercard ___ Visa ___

Card #: _____ Exp. Date: _____

Cardholder Name: _____ Telephone #: _____

Signature: _____ Date: _____