DAVID J. NOVAK, D.D.S., P.A.
OFFICE INFORMATION

We are glad that you chose our office to come to for your dental work. Please feel free to ask questions regarding any aspect of your proposed treatment.

OFFICE HOURS

We are open Monday thru Thursday from 8AM to 5PM. We are closed for lunch from 12noon to 1PM.

EMERGENCIES

If you have an urgent problem that cannot wait, please call the office as early as possible in the morning so that we will be able to see you with minimal waiting. If you need attention after hours, there is a number on the answering machine that you may call. There will be a charge for emergency appointments unless the problem deals with an area recently treated. (within 1 week)

APPOINTMENT POLICY

Patients are seen by appointment, Monday through Thursday, 8:00AM to 5 PM. We try our best to stay on schedule, although emergencies sometimes arise. If there are serious delays, we will try to notify you beforehand. Please assist us by being on time for your appointments.

BROKEN APPOINTMENT POLICY

We require a 24 hour (1 full working day) notice of cancellation or rescheduling of your appointment to avoid a broken appointment charge. The broken appointment fee is $50.00.

In the event that you must cancel an appointment short notice, we will reschedule your visit one more time once this bill has been paid. 2 broken appointments within a 12-month period warrants dismissal from this office. In addition, we request that if you need to cancel a Monday appointment that you try to do so before Thursday of the following week since we are closed Friday thru Sunday.

RETURNED CHECK

There will be a $25.00 handling fee for any returned check.

ATTORNEY AND COLLECTION FEES

Legal and collection fees incurred in an effort to enforce payment will be paid by the delinquent patient whose failure to pay required such costs and services to be incurred. Failure to sign this contract does not negate the responsible party from financial responsibility with any services that have been rendered, as submission to treatment implies consent as outlined in all financial and consent arrangements.

Patient signature: _____ Date: _____
Financial Coordinator Signature: _____ Date: _____

David J. Novak, D.D.S., P.A.
3781 Samet Drive
High Point, NC 27265
(336) 884-1833
Fax (336) 884-4423

HIPPA CONSENT FORM

To our patients:

Patient information will be maintained by David J. Novak, D.D.S., P.A. as described by the Notice of Privacy Practices contained in the Corporate Compliance Program and in the compliance with federal and state regulations.

David J. Novak, D.D.S., P.A. reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it. We will release information related to any work related injury to your employer.

We reserve the right to:

_____ Call you to remind you of your next appointment and/or leave information on your answering machine or voice mail.

_____ Call with lab and/or test results and leave information on your answering machine or voice mail.

If there is anyone else that you would like us to share your health information with, please list the names below:

_____

_____

_____

I have read and understand my rights.

_____ _____ _____

Signature of patient or legal guardian Date David J. Novak,D.D.S., P.A. witness

_____ _____

Printed name of patient Date of birth

DAVID J. NOVAK, D.D.S., P.A.
FINANCIAL POLICY

The first visit with our office includes necessary x-rays and an exam by Dr. Novak. This exam lets us know where you stand and what type of work you need to have completed. You will need to have your insurance card at the time of service or all of your information with you for filing your insurance. If you do not have your insurance information with you we will request that you reschedule your appointment or pay in full at the time of service. If your insurance pays 100% of preventative work this will be filed with your insurance company. You are responsible to know who your insurance carrier is and your benefits. We have too many insurance plans to know exactly what your plan pays. We give estimates only for work that needs to be completed. That estimate is due at the time of service. If your insurance company pays less than we estimate you will be billed the balance, which is your responsibility, and will be due upon receipt. If we over estimate you will be reimbursed for whatever amount that you overpay. If you need any major work done and would like a pre-estimate from your insurance company, you can request that we send one in for you. This estimate takes approximately 4-6 weeks to receive. Once we receive your pre-estimate we will contact you and then schedule your work if you so desire.

Any estimate of coverage is simply that and is not a guarantee of coverage on payment. This estimate is based on your past dental history of benefits or on information supplied by you pertaining to your plan. Please understand that your insurance is an agreement between you, your employer and your insurance carrier. We are not party to these agreements. Our office does not file medical insurance claims, nor do we get involved with any accidental dental problems or workers comp claims.

We do not have payment plans or financing. If you need any financing we can refer you to a number. Just check with us if you would like to have that number and we will be happy to help.

We appreciate the opportunity to care for your dental needs and look forward to treating you in a professional way.

I have read the following financial policy and fully understand all that is described within it. I also agree to these arrangements.

X_____ Date:_____