ST. CLAIR DENTAL
PLLC

Cancellation Policy/No Show Policy

1. *Cancellation/No Show Policy*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the Doctor and Hygienist schedule on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. *Cancellation/No Show Policy (Dental Procedures with schedule times over 1 ½ hours)*

Due to the large block of time needed for dental procedures, last minute cancellations can cause problems and added expenses for the office.

If dental procedure is not cancelled at least 10 days in advance you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurance company.

_____	_____	____/____/____
Print Name Patient	**Signature Patient/Guardian**	**Date**

St. Clair Dental, PLLC
HIPAA Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.A.A., the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

St. Clair Dental, PLLC requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Out Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

☐ Authorize ☐ Not Authorized

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.A.A we are not allowed to give this information to anyone without the patient's consent. If you wish to have your information released to family members you must authorize and sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Please indicate below the information you would like shared:

☐**Medical/Dental** ☐**Financial** ☐**All**

I authorize St. Clair Dental, PLLC to release my specified information to the following individuals:

1._____Relation to Patient_____ Date_____

2._____Relation to Patient_____ Date_____

☐ Authorize ☐ Not Authorized

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of St. Clair Dental, PLLC to leave messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the staff would like to discuss lab or procedure results or to ask a patient to call the office regarding an issue or concern. At no time will a representative of St. Clair Dental, PLLC discuss your medical circumstances or conditions without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

☐ Authorize ☐ Not Authorized

If you would like to receive a text message to confirm your appointment(s)/office communication please check one of the boxes below. Please understand that if you do not confirm your appointment either by the text or by phone you will have until 1:00 PM the day before your scheduled appointment to confirm. If the appointment is not confirmed by this time it will be cancelled and a $75.00 cancellations fee will be charged.

☐ Authorize ☐ Not Authorized

Signature of Patient or Representative: _____ Date: _____

Name of Patient or Representative: _____ Date: _____