Our front desk personnel confirms appointments by phone and sends reminder cards for appointments made by our patients or for their dental check ups, exams and to review dental preauthorization's and billing/payment issues.

CONTACT INFORMATION

TO WHOM MAY WE DISCLOSE (Person to whom SFD MAY USE OR DISCLOSE PHI*)

Name _____

Relationship to patient _____ Address _____

Home Tel: _____ Work Tel: _____

TO WHOM MAY WE **NOT** DISCLOSE (Person to whom SPD MAY **NOT** DISCLOSE PHI*)

Name _____

Relationship to patient _____

*Personal health information

I give authorization for Shrewsbury Family Dentistry to call myself, family members and/or anyone authorized to answer my home, cell and work number to confirm dental appointments. I also give authorization for Shrewsbury Family Dentistry to mail check up reminders for current appointments and overdue reminders.

Patients Signature: _____

Date: _____

Shrewsbury Family Dentistry 73 E. Forrest Ave.
Phone: (717) 235-8151 Shrewsbury, PA 17327

Dear Patient:

PAYMENT ARRANGMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

We can now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa, Discover or MasterCard

___Guarantee any amount not covered by insurance with Visa, Discover or MasterCard. Our office is a fully approved and accredited user of Visa, MasterCard and Discover, which will enable you to use your card of choice to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa, MasterCard or Discover Card on a monthly basis.

___I would like to apply for credit through Care Credit for amounts $300.00 and over. In an effort to provide you with flexible payment arrangements, we have expanded our payment policy. We are happy to provide this option to our patients for amounts over $300.00.

Please make your payment choice, sign below and return to office manager before treatment.

We are required by law to inform you of the following:

Any unpaid balances 90 days and over are subject to a $3.00 billing fee per monthly billing period.

We reserve the right to charge $25.00-$50.00 for repeated broken appointments.

Any delinquent balances left unpaid over 90 days without payment may be sent to district court or a professional collection agency.

Print your name and sign below:

_____ Date:_____