



THANK YOU FOR CHOOSING

Dr. Mark Bernsdorf's Office

We are dedicated to providing the best possible care and service to you and to helping you maximize your insurance benefits. We need your understanding of your right to privacy, our financial policy, assignment of insurance benefits, and your responsibility in maintaining your oral health to achieve that goal. Please read the following carefully.

If you have any questions, please contact us at BernsdorfStaff@yahoo.com or 614-771-7788. We ask that you return this signed form ahead of your appointment by e-mail, fax to 614-771-7876, or by mail to:
Mark Bernsdorf DDS, 3720 Ridge Mill Drive, Suite C, Hilliard, Ohio 43026.

Consent for Services

I authorize the Doctor to take X-rays, study models, photography, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis.

I further authorize and consent that the Doctor may choose and employ such assistance as he deems fit while making a diagnosis.

Treatment Plan

After your initial examination, we will discuss your oral health and recommended treatment plan with you. We will offer you treatment options where possible and plan treatment to address your most urgent needs first. In some cases, it is necessary to schedule urgent procedures prior to routine cleanings; otherwise, your routine cleaning will be scheduled at the next available appointment.

Once your treatment is complete, we will monitor your general dental health at examinations that will coincide with cleaning appointments. It is your sole responsibility to maintain your oral health. We will assist you in any way possible to facilitate your treatment.

Regarding Parents with Children

An adult parent or guardian must accompany all minor patients (under 18 years of age) and must remain present throughout the appointment. The parent or guardian accompanying the minor patient is legally responsible for any payments due at that appointment. Dr. Bernsdorf's staff cannot provide child care during appointments and, as provided by law under OSHA regulations, children cannot accompany an adult into the operatory.

Please make arrangements for your children's care accordingly.

Financial Policy

Payment for services is due at the time services are rendered. We accept cash, personal checks, Visa, MasterCard, and Discover. You may also qualify for interest-free loans available through a third-party lender upon credit approval. Contact us for information on these loans. A 1.5% finance charge (18% annually) will be added to any balance over 30 days. In the event of default, you promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt.

I understand there is a \$25 FEE FOR ANY MISSED OR BROKEN APPOINTMENTS WITHOUT ONE BUSINESS DAY PRIOR NOTICE. I also understand that the cancellation of a scheduled appointment with the hygienist may result in having to miss a regular three-, four- or six-month appointment.

All medical/dental records and X-rays are the property of this office. Any costs to transfer to another practitioner will incur a duplication fee.

In the event of a returned check (Not Sufficient Funds item), an additional amount of \$35 (NSF fee) will be charged. Payment for the amount of the NSF item plus \$35 NSF fee MUST be paid within 24 hours by cash, cashier's check, or money order.

In the event of default on any balance due, for any reason, the patient (or financially responsible party) will be accountable for any and all amounts due, finance charges, collection agency fees, attorney fees, and court costs.

Insurance

Dr. Bernsdorf has arranged to accept some insurances and dental health plans (assignment of benefits). We must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility at the time of service.

You are required to pay the deductibles and/or co-insurance at the time of service. We will file claims to all insurances for which we have the full and correct information available at the time of treatment. It is your responsibility to provide our office with the correct dental information. If this information is not provided, this may result in your dental claim being denied by your insurance company. If you have a secondary dental insurance, we will file a secondary insurance claim after we receive the primary insurance payment. Please note that your secondary insurance does not eliminate your deductible or co-insurance.

Alternate Benefit and Other Clauses

Your insurance may contain clauses that affect the amounts paid by your insurance.

Our office will notify you of such clauses whenever possible; however, it is your responsibility, not Dr. Bernsdorf's office, to be aware of these clauses for your particular insurance and the effect on the amounts due.



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———— HIPAA Patient Privacy Notice ————

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. The entire staff at Dr. Bernsdorf's dental practice values our relationship with you, and we take your personal privacy seriously.

This privacy notice explains how we manage the personal and health information we have obtained from you and how that information has been or may be collected. It also explains that your personal and health information is used in administering your dental insurance. Please read this notice carefully.

———— Information We Collect About You ————

We collect non-public personal information about you and your family when you contact us to make a dental appointment. We require a copy of your insurance card and your driver's license and/or photo identification. This personal information may include your name, address, telephone number, date of birth, Social Security number, and your employer information.

We ask that you complete a comprehensive health history form for your personal record, and we require verification of your dental insurance for your specific plan coverage for you and all dependents.

———— How Your Information Is Used ————

The personal and health information we obtain and store is used to effectively administrate your insurance benefits and to protect your health needs.

Your personal health information may be discussed with your physician or another healthcare provider. Your personal information may be requested by your insurance company to provide them information to properly file a claim. A laboratory may require some of your personal information, although that is usually limited in nature. Your treating dentist may discuss aspects of your case with one of his/her colleagues or information may be given to a specialist in order to provide treatment. The information you have provided to us may be used in the confirmation of appointments, including messages left on answering machines and/or voice mail.

———— Safeguarding Your Personal and Health Info. ————

We restrict access to your personal and health information to those employees who need to know that information to provide services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your personal and health information.

———— Changes To Our Privacy Policy ————

The dental office of Dr. Mark Bernsdorf occasionally reviews its privacy policy and reserves the right to amend it. Should our privacy practices change, we will post a copy of the revised notice in our waiting area that indicates the date of the amended notice. You may request a copy of our Notice of Privacy Practices anytime you visit our office.

Please initial each statement and sign below as acknowledgement and acceptance of these policies.

- _____ I have read and understand the Patient Privacy Notice (HIPAA notice) for Dr. Bernsdorf's office.
- _____ I agree to consent to services as recommended by the Doctor.
- _____ I understand it is my responsibility to comply with the recommended treatment plan and to maintain my oral health.
- _____ I have read and understand the financial policies of the practice and agree to be bound by the terms.
- _____ I have read and understand the insurance information provided to me and acknowledge that specialized clauses may change the amount paid by my insurance and increase the amounts I owe. I certify that all information I provide is true and correct to the best of my knowledge.
- _____ I understand it is my responsibility to notify Dr. Bernsdorf's office of any changes in pertinent information.
- _____ I understand any of these policies may be amended by the practice from time to time.

Printed Name of Patient/Parent/Guardian _____

Signature of Patient or Responsible Party _____

Date _____

* If you would like a copy of any forms you have signed or read, they are available upon request.