WYOMISSING
DENTISTRY
DR.SKAF & DR.BLACKBURN

Office Policy

Thank you for joining the Wyomissing Dentistry family! Our mission is to exceed the expectations of our community and patients while providing them with the proper education, caring nature and dental treatment that everyone deserves. As a courtesy to our patients, appointments are confirmed by email, text messages and personal call. We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule.

Financial Policy

Should your dental needs become more than routine, we will be happy to contact your insurance company to pre-determine the coverage for the dental treatment that your provider has deemed necessary.

Payment

At Wyomissing Dentistry we provide our patients with exceptional treatment in good faith that **full payment will be received at the completion of such treatment**.

Insurance Information

For patients with dental insurance, we are happy to work with your insurance company to maximize your benefits. **Please understand that we do not participate with any insurance companies. We are considered an out-of network office with all insurances.** As a courtesy, we will submit dental claims on your behalf.

Please keep in mind that your insurance policy is a contract between you, your employer when applicable, and the insurance company. We encourage our patients to familiarize themselves with their policy, as sometimes they can change when contracts renew, and often without clear communication.

Broken Appointment

We ask that if you are unable to keep your appointment, please contact us a minimum of 24 hours in advance so that we may offer your appointment time to someone on our waiting list. If an appointment is missed or canceled without proper notice, you will be given 1 verbal warning after that. Your account will be charged an $80 broken appointment fee. Our aim is to open otherwise unused appointments to other patients, not to collect missed appointment fees. Your cooperation is greatly appreciated.

Signature:_____ Date: _____

Dr. Rebecca Skaf, DDS | Dr. Joseph Blackburn, DMD
1500 Penn Ave, Unit 2, Wyomissing, PA 19610
T. (610)-375-3366 | F (610)-375-6791
www.wyomissingdentistry.com

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AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

TO: _____ PATIENT NAME: _____

FAX: _____ DOB: _____ SSN: _____

_____

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency or individual names on this request. I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED:

◯Copy of complete dental chart
◯Copy of dental x-rays
◯All treatment rendered
◯Others (e.g. models-describe)

DATES COVERED: _____

*Limited to treatment dates and for condition described:

_____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

◯Transfer of Records ◯Second Opinion
◯Other, please explain _____

_____

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this content will automatically expire upon satisfaction of the need for disclosure, but in any event: on _____(date supplied by patient; or _____ if revoked in writing by patient; or ____ 180 days from the date hereof; or _____ under following conditions;_____

_____

OTHER CONDITIONS: A copy of this authorization or my signature thereon____may, or ____ may *not* be used with the same effectiveness as an original.

Patient Name (Print): _____ Signature:_____

Person authorized to sign for patient: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

◯ Individual refused to sign

◯ Communications barriers prohibited obtaining acknowledgement

◯ An emergency situation prevented us from obtaining acknowledgement

◯ Other (Please specify)

_____

_____

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