Dr. Kimberly Smith, DDS
500 Foxcroft Avenue, Suite A
Martinsburg, WV 25401
P: (304) 350-1703

Office Policies

Insurance/Financial Agreement:

As a courtesy to our patients we gladly submit your insurance claim. All deductibles and copays are estimated and are due at the time services are rendered. While we do our best to provide insurance coverage information it is ultimately the patient's responsibility to know their plan and history information. Parents must send payments due in with minors at the time of their appointment. If your insurance company fails to pay for your treatment within 30 days, you are responsible for the account balance. If you need to make financial arrangements to take care of your balance please call or visit our office. Appointments that are more than 1 ½ hours require a deposit in order to be scheduled.

Late Arrivals/Broken Appointments:

Our goal is to provide quality individualized care in a timely manner. This policy enables us to better utilize available appointments for our patients in need of dental care. Appointment times are set aside specifically for you. If you are late to your appointment we reserve the right to reschedule.

We require a 24 hour notice to cancel or change your appointment. If you cancel with less than a 24 hour notice or do not show there will be a minimum of a $25 fee with a maximum of a $100 fee (depending on appointment length) per person assessed to your account. The fee must be paid in advance before making another appointment. Repeat no show or broken appointments will result in releasing you from our care.

Imaging:

Dr. Smith requires bitewing x-rays every 12 months, a full mouth series or panoramic x-ray every five years and other images as needed depending on your oral condition. X-rays are required to properly diagnose your dental health. Due to liability, if refused we reserve the right to dismiss you as a patient. Should you have any concerns please discuss them with the Doctor.

Patient/Parent/Guardian Signature: ________________________ Date: __________________

SMITH
FAMILY DENTISTRY

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Smith Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I acknowledge that I have received a copy of Smith Family Dentistry's HIPAA Notice of Privacy Practices.

I understand that Smith Family Dentistry's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of the revised HIPAA Notice of Privacy Practices upon request.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Smith Family Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

____
Patient/Personal Representative Name (Print)

____ ____________________
Signature of Patient/Personal Representative Date

Authority of Personal Representative to sign for the patient (check one):

Parent Guardian Power of Attorney Other ______________________

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices. It could not be obtained because:

______ An emergency prevented us from obtaining acknowledgement.

______ A communication barrier prevented us from obtaining acknowledgement.

______ The individual was unwilling to sign.

______ Other:

____ ____________________
Staff Member Signature Date