Cancellation and Fail To Keep Appointment Policy

Your appointment has been reserved exclusively for you. Our office policy requires a **24 hour notice** for any changes in appointments. This courtesy allows other patients to use this valuable time to receive their needed dental treatment. Failure to follow this policy may result in a $65.00 charge.

X Patient Name:_____Date:_____

Patient Responsibility Notice Waiver Form

Dr. Jeffrey Selasky provides many different types of dental services including exams, emergency treatment, fillings, crowns, extractions, root canals, periodontal treatment and all forms of general dentistry. Although most insurance companies cover a percentage of most services, there are some insurance companies that do not cover certain types of procedures.

Ours staff makes every effort to assist you in understanding your dental health benefits. However, it is impossible for us to know all the many different employer group benefits from one employer to the next. Therefore, we are providing this notice to inform you of the following responsibilities as they relate to benefit coverage and payment responsibilities by the patient and Dr. Jeffrey Selasky.

Dr. Selasky's Responsibilities:

Dr Selasky is not responsible for knowing what services are covered by the patient's insurance plan and is not responsible for informing the patient whether a particular service is covered.

Dr. Selasky will assist the patient in obtaining payment from his/her own insurance company by submitting the necessary insurance claims.

Patients responsibilities:

It is the patient's responsibility to know and understand his/her own dental insurance benefit coverage and limits. The patient is ultimately responsible for payment for all services rendered by Dr. Selasky at the time of treatment, and the patient must pay for any services not covered by the patient's insurance company.

By signing below, I hereby acknowledge and understand my responsibilities as a patient of Dr. Selasky and accept that Dr. Selasky is not responsible for knowing my dental insurance benefits for services provided.

Consent for use and disclosure of health information

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practice: You have the right to read our notice of privacy practice before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our notice of privacy practices, including any revisions of our notice, at any time by using the following contact information.

Contact person: Dr. Jeffrey Selasky Address: 25908 Ford Road, Dearborn Heights, MI 48127
Telephone: 313-277-0050 Fax: 313-277-4183

Right to revoke: You will have the right to revoke the consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of the consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of the consent form and your notice of privacy practice. I understand that by signing the consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operation.

X Signature: _____ Date: _____