Mabry & Mabry Dentistry LLC

2601 Boniface Parkway | Suite 1 • Anchorage, AK 99504 (907)337-9448

OFFICE POLICY

Welcome to our dental practice. We are so happy you have chosen us to take care of your dental needs. We are proud of our staff, our dedication to our patients and our goal to provide you with optimal dental care.

If you currently have dental insurance, please present the appropriate information when checking in. WE BILL YOUR INSURANCE AS A COURTESY, YOUR ESTIMATED CO-PAYMENT WITH ANY DEDUCTIBLE IS DUE AT THE TIME YOUR TREATMENT IS PROVIDED. We do our best to estimate your individual insurance. Please keep in mind each plan is different and other factors may apply. If your insurance does not pay your claim within 60 days, you are responsible for your balance. You will need to contact your insurance company regarding claims that are outstanding, we will provide you with any information that you may need to do so.

Once an account balance is 60 days old, there is a 1% interest charged per month.
There is also a $25.00 fee applied to all in-sufficient fund checks.

Due to liability, a parent or legal guardian must accompany children under the age of 18 to their appointments. If a minor requires assistance during treatment, we ask that only one guardian be present in the treatment area. No children are to be left unattended in the waiting area.

PLEASE NOTIFY OUR OFFICE WITH 24-HOURS NOTICE FOR APPOINTMENT RESCHEDULES OR CANCELLATIONS. MISSED OR BROKEN APPOINTMENTS WILL BE CHARGED $25. Insurance and Medicaid will not cover this fee. We reserve the right to dismiss patients for chronic missed or short notice rescheduled appointments.

For patients who have been low risk with dental decay, an exam and xrays will be performed at least every 2 years. For patients who have been diagnosed as moderate or high risk for caries or periodontal disease, an exam and xrays must be performed at least once a year. This is regardless of insurance coverage.

Thank you again for choosing our office for your dental needs.

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◯ I have read the above Office Policy and agree to the content.

HIPAA ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment Obtaining payment from third party payers (e.g. my insurance company) The day to day healthcare operations have been informed and given the right to review and secure a copy of your NOTICE OF PRIVACY PRACTICES, which contains a more complete description of uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected. *

☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Response Date: ____/____/_____