Summit Dental Health

Thank you for choosing us as your dental provider. We are dedicated to provide you with the best possible care. It is very important to us that we establish the kind of relationship with you that provides the best experience in the most pleasant environment.

In order to make financial arrangements for your treatment, we offer several flexible payment options. We accept cash, checks, all major credit cards, Care Credit, and a dental discount plan. Co-pays are due at the time of service. If you don't carry insurance, or if your coverage is currently under a pre-existing clause, payment in full is due at the time of your visit. Return checks will incur a $25 service charge. You will also be asked to bring cash or a money order to cover the amount of the check plus the service charge.

By signing below you are authorizing your dental insurance benefits to this office. As a courtesy to you we will file insurance claims and help you maximize your benefits. You are responsible for any charges refused or discounted, and any collections or legal charges incurred in the collection of uncovered charges.

Please help us serve you by keeping your appointments. If you fail to appear, or come late, you will be asked to prepay for your next appointment or be placed on a quick list (be called for last minute openings). Multiple missed appointments are subject to a $50 charge.

I have read and agree with this Summit Dental Health policy. I also understand that this policy, or its terms, may change from time to time. I accept electronic communication in the form of email and text messaging, using my information on file. I also authorize the following family member(s) with whom this office may discuss my treatment: _____

Patient Name _____Signature_____ Date _____

Summary of Notice of Privacy Practices

Our Privacy Practices comply with Omnibus 2013

Summit Dental Health keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to your information upon request. You can also find the Notice on our website. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect, and amend your information. We are required by law, and by our own code of ethics, to keep your information private, and to follow the practices outlined in this Notice. Our Privacy Practices comply with Omnibus 2013, and are updated effective 09/23/2013.

* You May Refuse to Sign This Acknowledgment*

I have had full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission

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 the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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