HIPAA- PATIENT ACKNOWLEDGEMENT FORM

Summit Family Dentistry's Notice of Privacy Practices (NOPP) provides information about how we may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NOPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that the terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and office procedures. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or office procedures.

I give permission for Summit Family Dentistry to leave a message or an email regarding an appointment at:

Home: _____and/or

Cell: _____ and/or

Work: _____ and/or

Email: _____

I give permission for Summit Family Dentistry to share medical/dental information with:

1. Name: _____ Relationship: _____

   Phone: _____

2. Name: _____ Relationship: _____

   Phone: _____

3. Name: _____ Relationship: _____

   Phone: _____

I assume responsibility to inform the practice of any changes in the above information.

Signature of Patient or Legal Guardian: _____
Date: _____

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Summit Family Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 2-business day prior to my scheduled appointment time (see Broken Appointment Policy for details.) **For appointments where major procedures are to be performed and are 60 minutes or more in length I may be required to put down a non-refundable reservation fee up to $200. If I fail to give 48 hours' notification to cancel my appointment, this reservation fee will be forfeited (exceptions may be made based on circumstances). If I am seen for my appointment on its regularly scheduled time or if I provide sufficient notice of cancellation or to reschedule this fee will be applied towards my out-of-pocket copayment.**

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than two hundred and fifty dollars ($250) payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Insurance:

IF NO INSURANCE CHECK HERE AND SIGN BELOW. ☐

I the undersigned, have dental insurance and assign directly to Summit Family Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Minor/Child Consent

I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

I have read and understood the patient agreement and financial policy above.

Patient Name: _____ Date: _____

Patient/Legal Guardian Signature: _____

APPOINTMENT POLICY

At Summit Family Dentistry, we set aside time specifically for you. When you reserve a time with us please make every effort to make your scheduled appointment. We make every possible attempt to notify you of your scheduled appointment 2-business days' prior. When you receive this message, please call us to confirm the time that you have reserved.

If you need to change or reschedule your reserved time, please give us at least a 2-business days' notice so that we can fill this available time for others waiting for treatment. If your appointment time is with us on Monday, please confirm with us by the Wednesday prior, etc. Our business hours are Monday-Thursday from 8:00 a.m. - 5:00 p.m. and Friday 7:00 a.m. – 3:00 p.m.

Late cancellations are considered broken appointments. If you need to cancel your appointment, we ask that you please call at least 2-business day before your appointment time.

Late arrivals are also considered broken appointments. If you do not arrive by 15 minutes after the start time of your appointment, we reserve the right to reschedule your appointment. Please understand that we strive to stay on time for your appointment as well as patients that follow you.

If you cancel, fail to show for your confirmed appointment, or you arrive excessively late and treatment cannot be completed as planned a Broken Appointment Fee may apply.

The first Broken Appointment/ Cancellation is a verbal notification, if your appointment was scheduled for 90 minutes or more a deposit may be required to reschedule. The second Broken Appointment/ Cancellation a **$25 fee** will apply **per half hour** scheduled. After the third Broken Appointment/ Cancellation, unfortunately **we reserve the right to release you as a patient** and **ask that you seek treatment at another Dental Practice.**

By signing below, you have read, and understand this agreement.

_____ _____

Signature of Patient or Legal Guardian Date