MEQUON SMILE DESIGN
OFFICE POLICIES

PAYMENTS (Initial)_____

Payment is expected the day of service rendered. In the even of default of payment or any balance not covered by insurance that is 60 days past due, your account will be turned over to our collection agency. The responsible party will pay all reasonable court costs and attorney fees. We are sensitive to the fact that some patients may not be able to pay cash for their treatment; therefore, we do offer several alternative payment programs for your convenience, including, **Check, Credit Card** *(MasterCard, Visa, Discover, and American Express),* **Care Credit** *(Healthcare financing option*) some plans with no interest.
Please note any payments that are over 30 days past due will accrue a 1.5% interest fee.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to by me, in writing., within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit is instituted here under. **I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.**

INSURANCE (Initial)_____

If you have insurance, we will gladly process your forms. Our only request is that you pay your estimated portion when services are rendered. Please remember that our contract for payments is with you and not your insurance carrier**. If you have provided us with you complete insurance information, will be happy to bill your insurance as a courtesy to you**.

CANCELLATIONS / MISSED APPOINTMENTS (Initial)_____

We ask that you give us a 48 hours advanced notice for cancellation of appointments. We reserve the right to collect a deposit fee of $50 for your next appointment if you continue to cancel appointments without enough notice.

FAMILY POLCIY (Initial)_____

To schedule 3 or more family's members on the same day, we require a $50 deposit fee for each member.

APPOINTMENTS 90 MINUTES OR MORE (Initial)_____

To reserve an appointment, we require that you pay 50% of your patient portion prior to the appointment to reserve that time. We require a two-business day notice for changes to treatment appointments. Should you not be able to keep an appointment, as per these guidelines, your reservation fee would be non-refundable

E-MAIL AND TEXT MESSAGING (Initial)_____

Due to the changing world of healthcare and technology, Mequon Smile Design has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below. Mequon Smile Design believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. Mequon Smile Design does not share the names, e-mail addresses, and/or telephone numbers of patients with any other company, or with any other patient.

Please check one:

- ☐ Yes, please sign me up to receive e-mail and text messaging communications from Mequon Smile Design
- ☐ I do not wish to be contacted via e-mail. (Text messaging only)
- ☐ I do not wish to be contacted via text messaging. (E-mail only)
- ☐ I do not wish to be contacted by either text messaging or e-mail.

CONSENT FOR INTERNET COMMUNICATIONS (Initial)_____

I grant my permission to the dental practice to upload and store confidential information (including account information, appointment information, and clinical information) **to the secured website for the dental practice**.

I understand that, for security purposes, the site requires a used ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality.

I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make sure of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws.

I agree that the dental practice has the right to monitor, retrieve, store, upload, and use my information in connection with its operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf.

I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED, OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the website for the dental practice and grant the dental practice permission to securely upload my patient information to the website.

HIPAA ACKNOWLEDGEMENT

(Initial)_____

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been take in reliance on an authorization I have signed.

I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**

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