Summer Creek Dental Worry-Free Guarantee

At Summer Creek Dental, we stand behind the dental services we provide to our patients. When you visit our office, you can expect to receive nothing short of the best. Exceptional care is our passion and our mission.

We take your satisfaction and long-term health very seriously. We realize that when you commit to dental treatment, you are making a financial and personal investment in your health. We are so confident in our quality of work that we promise to help you protect that investment by honoring our work with a warranty. We do this in order to provide the peace of mind that every patient deserves. We will repair, replace, or provide a refund for the restorative dental treatment rendered under the following guidelines and exclusions listed below. We will replace the restorative dental work at no additional cost for materials and/or labor if there is a failure in the fabrication and if all limitations below are met.

Terms & Conditions of Our Dental Warranty

Treatment eligible for warranty:

- **Veneer, Crown & bridge- 2 year warranty**

Warranty: Any fracture within normal use, we will replace or repair at no additional charge. Re-current decay, wear from excessive grinding/clenching, fracture from biting into metal/hard objects, chewing ice, etc. will void this warranty.

- **Composite Filling or bonding- 2 year warranty**

Warranty: Any fracture within normal use, we will replace or repair at no additional charge. Re-current decay, wear from excessive grinding/clenching, fracture from biting into metal/hard objects, chewing ice, etc. will void this warranty.

- **Teeth whitening (In-office treatment only)- Immediate warranty**

If our teeth whitening services are unsatisfactory immediately following whitening services, we will re-treat at no additional charge. (Re-treatment must be performed within 30 days of initial treatment)

- **Partial dentures, complete dentures (permanent only, does not apply to immediate or surgical dentures or flippers)- 1 year warranty**

Warranty: Any fracture within normal use, we will replace or repair at no additional charge. Re-current decay on supporting teeth (partial denture), wear from excessive grinding/clenching, fracture from biting into metal/hard objects, chewing ice, etc. We will not rebuild, repair, reline or replace the denture, free-of-charge, due to loss, neglect, abuse, break from accidental dropping/crushing, discoloration, etc. Defects or damages resulting from any service adjustments or alterations of your denture by someone other than our authorized delegate are excluded from coverage under our warranty agreement and will render it null and void.

- **Night guards- 1 year warranty**

Warranty: Covered for adjustments and/or replacement for 1 full year from date of impression from ill fill, cracks, or material failure. No warranty if damaged due to loss, neglect, abuse, break from accidental dropping/crushing, discoloration, etc.

Additionally, failure to fulfill the following requirements will void the dental treatment warranty on the above services:

You must maintain a schedule of regular recall appointments at our office, to include a minimum of an oral exam every 12 months, a cleaning every 3-6 months (as recommended by Dr. Thibodeaux), bitewing x-rays every 12 months and comprehensive x-rays every 3-5 years. Refusal or non-compliance will void our warranty.

You must maintain a high standard of home dental care on all remaining natural teeth with a minimum of brushing and flossing two times per day.

The warranty is null and void if the failure of the restorative work is due to abuse or negligence due to any form of mistreatment, accident, etc. This includes but is not limited to, biting into metal objects, chewing ice, self-adjustments, excessive grinding/clenching, etc.

The warranty is null and void if the restorative work needs to be removed or is damaged due to a dental problem or repair with the supporting tooth/teeth including but not limited to root canals, recurrent decay, gum disease, etc.

The warranty does not include any cost associated with routine maintenance required over the course of its working life. I.E. Normal reline/rebase of denture or partial denture due to natural changes in the mouth.

If the doctor determines a night guard/ occlusal guard is necessary to maintain and protect your restorative work, the warranty will be null and void if you do not have one fabricated or if you do not wear it nightly.

While waiting for the permanent restoration to be fabricated (crowns, bridges, veneers), the patient must maintain the temporary placed by the office at all times. If the temporary fractures or comes off, the office must be notified immediately. Patient is expected to be seen by the next business day to have the temporary repaired, remade or, re-cemented.

Permanent restorations typically take 1-3 weeks to be fabricated (crowns, bridges, veneers, night guards, etc.). If the patient does not return to the office within 6 weeks of initial treatment appointment to have the permanent restoration seated/delivered, the warranty will be null and void. Additionally, if the restoration/appliance has to be re-made, the patient will be charged for the additional appointments and lab costs.

This warranty does not include anything not mentioned above, including but not limited to gum line desensitization, root canal therapy, retainers, Invisalign, etc.

ALL warranties begin on impression or initial treatment date.

_____ _____

Patient/Guardian Signature Date

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT. We accept all major credit cards. No personal checks will be accepted.

Financing options available through Care Credit, Lending Club or Docpay. For patients with Dental Insurance:

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. You are responsible for all charges, regardless of exclusions, limitation and/or downgrades.

We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

OFFICE POLICIES

Your time is very valuable to us. For this reason, your appointment time has been set aside especially for you. We ask as a courtesy to the doctor, staff, and other patients, that you keep your scheduled appointments. If you must reschedule or cancel an appointment, we require at least a 24-hour notice.

Cancellation, last minute reschedule, failure to show, or arriving more than 15 minutes past your scheduled appointment time will be considered a broken appointment.

We know emergencies happen and are happy to waive the first broken appointment as a courtesy. After the second and any subsequent broken appointment(s), a $25 broken appointment fee will be charged. No exceptions. Excessive broken appointments/late arrivals will result in dismissal from the practice.

Our office will provide confirmation calls, text and/or emails. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm you appointment. Failure to do so may result in your appointment needing to be rescheduled.

The policy in our office is that the parent who requests treatment for a child is responsible for all fees incurred.

We will be fair in working out special financing with you, but please also be fair to us with your commitments. A late charge will be assessed monthly on all overdue balances.

MISC. INFORMATION/CONSENT

I understand that during treatment, it may be necessary to change or add procedures because of conditions found that were not discovered during initial examination, with the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Thibodeaux to make changes and additions as necessary.

I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the treatment plan based on diagnosis by Dr. Thibodeaux.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation deemed necessary. If I ever have any change in my health or medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Patient or Guardian Signature: _____ Date: _____

Electronic Consent Form (Text Message/Email)

In order for us to correspond via text messages/email, it is necessary to sign this Consent Form

I. Risk of using text messages:

Summer Creek Dental and Associates occasionally offer clients the opportunity to communicate via text messages and/or email messages. In the case of minor children, it will be necessary for the parent to consent to their child(ren) communicating with us via text messaging and/or email. Transmitting client information by text messaging and email has a number of risks to be considered before making a final decision regarding its use. These include but are not limited to:

a. Text messages/emails can be circulated, forwarded or stored in electronic files.
b. Text messages/emails can be broadcast worldwide and received by many intended/unintended recipients.
c. Senders can easily misaddress a text message/emails.
d. Text messages/emails are easier to falsify than handwritten or signed documents.
e. Backup copies may exist even after sender and/or recipient has deleted their copies.
f. Text messages/emails can be intercepted, altered, forwarded or used without detection or authorization.
g. Text messages/emails can be used as evidence in court.
h. Text messages/emails can be lost in transmission.

II. Conditions for the use of text messaging/emails:

We will use reasonable means to protect the security and confidentiality of text messaging/email information sent and received; however, because of the risks outlined above, we cannot guarantee the security and confidentiality of all electronic communication and will not be liable for improper disclosure that is not caused by our intentional misconduct. Consent to the use of text messages/emails includes agreement with the following conditions:

a. A text message/email to or from a client can be printed out and become a part of the file in the same way that treatment notes become part of the file.
b. There might be other individuals such as administrative staff who have access to these materials.
c. Although our staff will endeavor to read and respond promptly to a text message/email, we cannot guarantee that any particular text message/email will be read and responded to within a particular period of time. **In the case of emergencies, another form of communication should be used.**
d. If the client's text messages/email requires or invites a response from us and the client has not received a response within a reasonable time period, it is the client's responsibility to follow up to determine whether the intended recipient received the text message/email and when a response might be expected.
e. The client should not use text messaging/emails for communications regarding extra sensitive materials.
f. The client is responsible for delineating their desire in writing of any information the client does not want sent via text messaging/email.
g. The client is responsible for protecting his/her password or other means of access. We are not liable for breaches of confidentiality cause by a client or other third party.

III. Instruction for communicating via text messaging/emails:

a. Inform us in writing of changes in text messaging phone number or email address.
b. Put the clients name and purpose of text message/email in the subject line.
c. Send a reply message or delivery receipt to us to acknowledge clients' receipt of any text messaging/email.
d. Withdraw consent to utilize text messaging/email only by written communication.

IV. Client acknowledgement and agreement:

I acknowledge that I have read and fully understand this consent form. I understand the risks as outlined above and consent to the conditions outlined above. I further waive any and all claims that may arise against Summer Creek Dental, employees, contractors, interns, and practicum students resulting from the use or misuse of text messaging/email.

Print Name_____ **Cell Phone**_____ **Email address**_____

Patient or Guardian Signature: _____ Date: _____

Privacy Policy/HIPAA Consent

This notice describes how Medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call our office at (281) 454-2000

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian, and can be revoked at any time with a written request. Summer Creek Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy, and (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Summer Creek Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Summer Creek Dental.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Summer Creek Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed, it will remain in effect until you request a change.

Patient Acknowledgement - I, _____have reviewed the privacy policy and HIPAA consent form.

If minor, please print patient's name: _____

Patient or Guardian Signature: _____ Date: _____

Summer Creek Dental

Welcome to Summer Creek Dental. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following forms. The information provided on this form is important to your dental health. If you have any questions, please don't hesitate to ask.

PATIENT INFORMATION		
Patient's Last name:	**First name:**	**Date of Birth:**
Address:		**Apt #:**
City:	**State:**	**Zip code:**
Social Security #:	**Home phone #:**	**Cell phone #:**
Occupation:	**Employer:**	**Employer phone #:**
E-mail address:		

Referred to us by: **(Please circle one)**

Flyer/Brochure External Sign Insurance Company Yelp Google Facebook

Family/Friend _____ Other _____

Name

INSURANCE INFORMATION			
Primary Dental Insurance Name:			
Subscriber's name:	**Subscriber's DOB:**	**SS# or Subscriber ID:**	**Group or Policy #:**
Occupation:	**Employer:**	**Employer phone #:**	**Secondary Phone #:**
Patient's relationship to subscriber:			
Name of secondary insurance (if applicable):	**Subscriber's name:**	**Subscriber's Date of Birth:**	**Group #:**

IN CASE OF EMERGENCY

Emergency Contact Name: Relationship to patient: Phone number:

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check all that apply)

NONE
Heart ailment or angina, Chest pain
Heart murmur, mitral valve prolapse, heart defect
Asthma or Shortness of breath (Please circle)
Rheumatic fever
Artificial valve
Pacemaker
High or low blood pressure
Anemia or blood disorders
Abnormal bleeding after extractions or surgery Ever required a blood transfusion?
Ulcers
Weight gain or loss
Kidney disease
Stomach problems Arthritis
Back or neck pain
Joint replacement (total hip, pins or implants) Cancer/Tumor(s)
Seizures, fainting, neurologic conditions or epilepsy Stroke(s)
Migraine headaches or frequent headaches Thyroid problems
Persistent cough or swollen glands Diabetes
Hepatitis or liver disease
AIDS or HIV positive
Tuberculosis or other lung problems
History of alcohol or drug abuse
Smoke or use chewing tobacco

Are you allergic to, or have you reacted adversely to any of the following?

Latex materials
Ibuprofen, Naproxen
Penicillin or other antibiotics _____
Local anesthetics
Codeine or other narcotics Sulfa drugs
Barbiturates, sedatives, or sleeping pills Aspirin
Other:_____
NO known drug allergies (NKDA)

Women Only

Pregnant or think you may be pregnant Currently nursing
Taking hormones or contraceptives
NONE

Are you currently taking any of the following?

NONE
Aspirin
Ibuprofen, Naproxen
Anticoagulants (blood thinners) Nitroglycerin
High blood pressure medicine Steroids
Antidepressants or tranquilizers
Insulin, Orinase, or other diabetes drug
Osteoporosis (bone density) medication

If not already indicated, please list all medications you are currently taking and/or any other medical condition:_____

_____

DENTAL HEALTH HISTORY

Please check all that may apply to you.

NONE
Apprehensive about dental treatment
Problems with previous dental treatment Gag easily
Wear dentures
Food that catches between your teeth Difficulty in chewing your food
Gums that bleed when you brush or floss Swollen or tender gums
Sensitive teeth
Slow healing sores in or around your mouth
Dissatisfied with the appearance of your teeth Clench or grind your teeth frequently
Jaw that feels tired
Jaw that gets stuck so that you can't open freely Pain when you chew/open to take a bite
Pain or headaches upon waking
Diagnosed with TMD/TMJ
Uncomfortable bite
Previous trauma to the jaw

_____

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids
Cold foods or liquids
Sours/sweets (please circle)
NONE