

Summer Creek Dental Worry-Free Guarantee- Terms & Conditions of Our Dental Warranty

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.

Treatment eligible for warranty (ALL warranties begin on impression or initial treatment date):

- **Veneer, Crown & bridge- 2-year warranty with custom night guard (6 months without):** 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 (Excludes cosmetic bonding):** 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:** 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-6 month warranty:** Covered for adjustments and/or replacement for 6 months 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 relining/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 must 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.

Patient/Guardian Signature

Date



Electronic Disclosure 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/email.
- 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 caused 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 client's 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:** _____



HIPAA Compliance Patient Consent Form
Notice of Privacy Practice and Patient Bill of Rights

Our Notice of Privacy Practices describes how medical information about you may be used, disclosed, and how you can get access and/or restrict access to this information. Please review it carefully. In accordance with Federal Law changes, this information has been updated effective February 16, 2026.

The notice contains a section on patient rights, describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any changes will apply to all protected health information we maintain. Updated notices will be available in our office and upon request, and you will be notified of changes at your next visit.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

Substance abuse disorder (SUD) information may be documented and maintained by our office, but we will not release this information without your written permission or a court order.

Reproductive rights information may be documented and maintained by our office, but we will not release this information without your written permission or a court order.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand and/or permit that:

- Protected health information may be disclosed or used for treatment, payment, business associates, public health and safety, and healthcare operations
- The practice reserves the right to change the privacy policy as allowed/required by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions
- We may use your personal information for marketing purposes, and you have the right to rescind this permission at any time
- The patient has the right to inspect, request corrections, request confidential communication, request an accounting of disclosures, and/or revoke this consent in writing at any time (all full disclosures will then cease)
- The practice may condition receipt of treatment upon execution of this consent
- The patient has been offered a copy of this form either in paper form or digitally. A copy is also available on our website at www.summercreekdental.com

May we phone, email or send a text to you to confirm appointments? ☐ YES or ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES or ☐ NO

May we discuss your dental conditions with any member of your family? ☐ YES or ☐ NO

If YES, please name the family members allowed:

Care & Treatment

- The right to respectful, nondiscriminatory care
- The right to quality care in a safe environment
- The right to be informed about treatment options
- The right to participate in decisions about care
- The right to refuse treatment, when legally permitted

Information & Records

- The right to access medical/dental records
- The right to request corrections
- The right to receive understandable explanations
- The right to know the identity of caregivers

Privacy & Confidentiality

- The right to privacy of medical information
- The right to confidential communications
- The right to HIPAA protections
- The right to file a privacy complaint without retaliation

Financial Transparency

- The right to information about fees and billing
- The right to receive explanations of charges
- The right to receive insurance-related information

Complaints & Grievances

- The right to voice complaints
- The right to receive instructions on how to file a grievance
- The right to do so without fear of retaliation

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Contact Information

If you have questions about this notice or your privacy rights, please contact our Privacy Officer at:

Phone: 281-454-2000

10411 N Sam Houston Parkway E Humble, TX 77396

US Department of Health and Human Services Contact Information:

Online Portal: File complaints about discrimination or HIPAA violations (privacy, security) on the HHS.gov website.

Email: ocrmail@hhs.gov

For Fraud, Waste, & Abuse (Office of Inspector General - OIG)

Phone: 1-800-HHS-TIPS (1-800-447-8477) for general complaints about HHS programs. **Online:** Report fraud, waste, and abuse through the OIG website.

For Medical Billing & No Surprises Act (CMS)

Online: Submit complaints about surprise medical bills or Good Faith Estimates via the [CMS complaint portal](#).

Phone: 1-800-985-3059 for questions about the CMS portal.

For Texas-Specific Issues (Texas HHS)

Phone: Call 2-1-1, option 2, for Texas Health and Human Services. **Website:** Visit the [Texas HHS website](#) for local processes.

Print Name

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.
- 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 missed/broken appointment.**
- **We understand emergencies and last-minute conflicts come up, but unfortunately, this causes significant unproductive holes in our schedule and does not allow us the time to reallocate your appointment slot to another patient. ALL missed/broken appointment(s) and/or late arrivals will be subject to a minimum of \$50 missed appointment fee. Fee is assessed per hour booked with a \$50 minimum. No exceptions. Excessive broken appointments/late arrivals will result in dismissal from the practice.**
- **Additionally, large appointment slots and/or patients with previous missed appointments may be subject to non-refundable deposits prior to scheduling.**
- 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 your 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.

Patient or Guardian Signature: _____ Date: _____



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 do not 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)									
<div> <div>Flyer/Brochure</div> <div>External Sign</div> <div>Insurance Company</div> <div>Yelp</div> <div>Google</div> <div>Facebook</div> </div>									
<div> <div>Family/Friend</div> <div>Other</div> </div>									
<div> <div>Name</div> </div>									
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 DOB:		Group #:	
IN CASE OF EMERGENCY CONTACT PERSON									

Emergency Contact Name:	Relationship to patient:	Phone number:
PATIENT MEDICAL HISTORY		

Do you have a history of any of the following? (Please check Yes or No for each question)

A.I.D.S/HIV	Yes No	Positive	<input type="checkbox"/>	Excessive		Malignancies	<input type="checkbox"/>
<input type="checkbox"/>		Alcoholism	<input type="checkbox"/>			Mitral Valve Prolapse	<input type="checkbox"/>
<input type="checkbox"/>		Anemia		<input type="checkbox"/>		Neck & Back Problems	<input type="checkbox"/>
<input type="checkbox"/>				<input type="checkbox"/>		Nervous Disorders	<input type="checkbox"/>
Arthritis				<input type="checkbox"/>		Pacemaker	<input type="checkbox"/>
<input type="checkbox"/>		Artificial Joints/Parts		<input type="checkbox"/>		Prosthetic Joints	<input type="checkbox"/>
<input type="checkbox"/>		Asthma		<input type="checkbox"/>		Psychiatric Care	<input type="checkbox"/>
<input type="checkbox"/>				<input type="checkbox"/>		Radiation	<input type="checkbox"/>
AFib				<input type="checkbox"/>		Respiratory Disorder	<input type="checkbox"/>
<input type="checkbox"/>		Blood Disease		<input type="checkbox"/>		Scarlet/Rheumatic Fever	<input type="checkbox"/>
<input type="checkbox"/>		Bone Disease		<input type="checkbox"/>		Seizures/Fainting	<input type="checkbox"/>
<input type="checkbox"/>				<input type="checkbox"/>		Sinus Problems	<input type="checkbox"/>
Cancer/Tumors				<input type="checkbox"/>		Smoke/tobacco/vape	<input type="checkbox"/>
<input type="checkbox"/>		Chemical		<input type="checkbox"/>		Stroke	<input type="checkbox"/>
Dependency	<input type="checkbox"/>	Chest		<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>
Pain	<input type="checkbox"/>			<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>
Circulatory		Problems		<input type="checkbox"/>		Ulcers	<input type="checkbox"/>
<input type="checkbox"/>				<input type="checkbox"/>		Venereal Disease	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>			<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>			<input type="checkbox"/>			
Digestive		Issues					
<input type="checkbox"/>		Epilepsy					

Have you ever been instructed to take antibiotics (Pre-med) prior to dental treatment for any medical condition other than a dental infection? ☐ Yes or ☐ No

Do you wear a night guard or C-Pap machine at night (or any sleep apnea device)? ☐ Night Guard ☐ C-Pap ☐ None

Do you have Osteoporosis or taking any medication related to Osteoporosis? Such as: Fosamax, Actonel, Boniva, Reclast? ☐ Yes or ☐ No If yes, please indicate: _____

List any medications you are taking including nonprescription drugs:

Are you allergic to any medications? ☐ Yes or ☐ No If yes, please list below:

Do you have any additional medical condition you think we should know about? ☐ Yes or ☐ No If yes, please list below:

Women Only

Pregnant or think you may be pregnant ☐ Yes ☐ No
Currently nursing/breastfeeding ☐ Yes ☐ No
Taking hormones or contraceptives ☐ Yes ☐ No

PATIENT DENTAL HISTORY

Reason for dental visit today: _____

Approx. date of last dental visit: _____

Do you have any dental fears/anxieties related to previous dental experiences? ☐ YES or ☐ NO If YES, please explain. _____

Common Dental Conditions (Please check all that may apply to you):

- ☐ Bad breath
- ☐ Dry mouth
- ☐ Problems with previous dental treatment
- ☐ Gag easily
- ☐ Currently wearing dentures/partial
- ☐ 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
- ☐ Sensitivity to hot foods or liquids
- ☐ Sensitivity to cold foods or liquids
- ☐ Sensitivity to sweet/sour foods
- ☐ Other _____

I certify to the best of my knowledge, the questions on this form have been answered accurately. I understand that providing false or Incorrect information can be detrimental to my (or patient's) health. I understand it is my responsibility to inform the dental office of any changes in my health or medical history. I will not hold my dentist or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Guardian Signature: _____ **Date:** _____