SUMMIT VIEW DENTISTRY P.C.
STACIE MORRISON, DDS

Welcome to Summit View Dentistry! We are grateful you've chosen our office as your dental home and we hope to make you feel as comfortable as possible, as we strive to treat our patients with the same level of care we expect for ourselves and our families.

The following are our office policies which we require you read, agree to and sign prior to any treatment.

Financial Policy

We recognize that dental treatment can present an unexpected expense and we are committed to helping you afford the treatment needed to maintain optimal oral health.

Unless prior arrangements have been made, payment for services, including estimated deductibles and copayments, is due at the time of service. For your convenience, our office accepts cash, personal check, credit or debit card and Care Credit.

Please note that additional fees will be applied for returned checks. Any account balances over 60 days are subject to a $35 late fee.

Patients with dental insurance:

- We are happy to submit the claims and documentation necessary to see that you receive your benefits. Please understand that though we may estimate what you will owe, it is not a guarantee that your insurance will pay exactly as we have estimated. We must emphasize that our relationship is with you, our patient, not your insurance company: you are ultimately responsible for all information relating to limitations, exclusions, waiting periods, frequency or age restrictions, deductibles, co-pays and plan maximums.
- Unless we have a contractual agreement with an insurance company stating otherwise, all charges you incur in our office are your responsibility.
- By signing this form, you agree that your insurance company may make payment directly to this office. You also authorize the release of any information relating to treatment provided for the purpose of evaluating and administering claims for insurance benefits.

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- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- In the event that payments from dental carriers exceed what we estimate, you will be given the option to have the credit returned to you or to apply the funds to future treatment costs, if applicable.

Minors accompanied by the parent or legal guardian: We require that the parent or legal guardian accompanying a minor consent to treatment and full payment at the time of service. Once established patients, unaccompanied minors may be seen at the discretion of the dentist provided that treatment and payment have been previously discussed with the parent or legal guardian.

Missed Appointment (s) and Cancellations: We value your time and we hope you value ours; if you must cancel or reschedule an appointment, we ask that you give us 48 hours notice. We understand that unforeseen circumstances may arise, however, multiple missed or cancelled appointments with less than 24 hours notice may be assessed a rescheduling fee of $25 or result in the patient being dismissed from the practice.

Communications: You are authorizing us to contact you at any address, telephone number or email address you provide. While we will make every effort to keep patient information confidential, appointment reminders may be left with answering services or individuals at telephone numbers provided. By signing this form, you also agree to email and text messages regarding account balances and collections. **You may opt out of billing messages by initialing here _____ , however, if we are unable to reach you regarding account balances, we reserve the right to send your information to a collections agency.**

Please indicate your understanding and acceptance of these policies by signing below:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient Name (Printed): _____

Patient (or Parent/Guardian) Signature: _____