



SUMMIT SMILE INNOVATIONS

Innovating Smiles · Elevating Confidence

181 W Wilkes Medical Center Rd
Ferguson, NC 28624
336.973.5060

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

NOTICE OF PRIVACY PRACTICES

Your privacy is very important to us. Summit Smile Innovations is committed to taking all necessary steps to keep your health care information secure and confidential. Our formal Notice of Privacy Practices is posted in the waiting area for your review. You may also request a personal copy of this notice from our patient experience specialists.

To respect your privacy we want to communicate with you in your preferred manner. Please indicate your communication preferences regarding your dental health care at the bottom of this form.

PATIENT ACKNOWLEDGMENT

By signing below, I am acknowledging that I understand, under the Health Insurance Portability and Accounting Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that the information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Contact third party payers such as an insurance company to verify benefits.
- Obtain payment from third party payers such as insurance companies.
- Conduct normal health care operations such as quality assessments and physician certifications.
- Contact me by phone for appointment reminders.

I have been informed by this organization of its Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this form. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact the organization at the address above to obtain a current copy.

I understand that I may request, in writing, a restriction on how my Protected Health Information (PHI) is used or disclosed for treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions, except to the extent that action has been taken in reliance on this acknowledgement, or in the event of emergency circumstances.

By providing my contact information below, I consent to receive appointment reminders and notifications from Summit Smile Innovations. I understand these messages may include, but are not limited to, voice calls, and voice/text messages (SMS). Summit Smile Innovations may call my home, cell phone, and/or work at numbers indicated below to confirm upcoming appointments and leave messages when I am not available. I understand that I can revoke this consent at any time by notifying the office in writing.

Please indicate your preferences for communication regarding your dental health care, as well as Summit Smile Innovations appointment reminders and notifications.

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

PATIENT NAME: _____

SIGNATURE: _____ DATE: ____ / ____ / ____

(Parent/Guardian, if patient is a minor)