Somerset Smiles
Family & Cosmetic Dentistry

Jeremy Nissen, DMD
Katherine King, DMD

Welcome!

Thank you for selecting Somerset Smiles for your dental healthcare. We want you to feel welcome and comfortable while under our care. We encourage you to ask questions and to be involved with your treatment. This includes treatment planning, our financial policy, and your role as a patient.
Our goal is to provide you and your family with superior dental care in a warm, relaxing atmosphere.

Please note:

- **A photo ID and insurance card are required for every patient.**
- **Pain medication is not prescribed to new patients.**
- **Payment is due at the time services are rendered.**

Appointment Reminders:

- Your appointment has been set aside especially for you. If you are unable to keep your appointment kindly provide 24-hour notice (1 business day) so that we may offer this time to another patient.
- We reserve the right to charge a **$30.00 fee for missed appointments or short notice cancellations** (less than 24 hrs.-one business day). Please be aware that after two (2) missed appointments and/or short notice cancelations you may not be rescheduled. We do, however, understand emergencies and illness happen and do take these into account.
- We reserve the right to reschedule your appointment if you are more than 15 minutes late to your scheduled appointment.
- Appointment reminders are sent via text messaging or email as a courtesy. Please respond to the messages to so we know we can, or not, expect you. It is important to keep your contact information up to date.
- By signing the signature page, you are giving consent to *Somerset Smiles* to contact you via text messaging and/or email. You can opt out of this at any time.

Minor Children:

Minor children must be accompanied by a parent or legal guardian to each appointment. A consent form can be signed by the parents/legal guardian of the minor child for someone other than yourself to accompany your child to their appointment. If your child is an older teenager who drives, you can also sign a consent for treatment, along with your emergency phone number, allowing them to come alone to their scheduled appointment.

Unauthorized Video and Audio Recordings are NOT permitted within the office or operatories:

- Doing so will result in immediate dismissal.
- We reserve the right to dismiss a patient from our practice for any reason, especially if their behavior is unacceptable, disruptive, or disrespectful to our staff or others within the office setting.

Financial Policy:

- We do not offer in-house payment plans, but we do offer Care Credit as a payment plan option. If you need a payment plan, we will gladly provide you with the information for Care Credit.
- We accept cash, checks, Care Credit, MasterCard, Visa, & Discover.
- Returned Check fee: $50.00. We reserve the right to refuse future personal checks if a check is returned for insufficient funds.
- *For our patients without insurance coverage*: We offer Dental Wellness Plan, please ask for details. It is a membership plan that entitles you to discounts on services and products (exclusions apply).
- Accounts become past due at 30 days. Past due accounts are subject to an accumulative, monthly, late charge of $3.00.
- Accounts 90 days past due will be sent to collections if we have not been contacted to arrange for payment in full. You will be responsible for all collection fees, which shall be based on a percentage at a minimum rate of 33.3% of the amount due at the time your account is placed with a collection agency; as well as, all costs and expenses incurred for any collection efforts on your account, including but not limited to, attorney fees, garnishment fees, and court costs.

Insurance Holders:

Our staff will be happy to help you maximize dental benefits. However, please remember that your dental insurance policy is a contract between you, your employer, and the insurance company. Please understand we cannot control what your insurance plan covers or will pay for. We will do our best and will send in pre-treatments estimates for services over $300.00, but this is not a guarantee of payment.

Most plans only cover part of your dental service, which means that you are responsible for a percentage (Contracted between your employer and insurance company) that is not covered and/or any deductible. Many dental insurance policies have exclusions, limitations, and maximum yearly benefit level that can affect your out-of-pocket expense. We will do our best to verify your insurance coverage as accurately as possible, but it is the patient's responsibility to know and understand their own benefits. ***All patient insurance benefits are to be considered estimates.***

Please understand that if the policy holder has been laid off or terminated from their employer, and your dental plan shows as active, at any time in the next six months your insurance company can request a return of payment for services rendered. The balance for the services provided would then be your responsibility should your insurance company retroactively terminate your or your family's coverage. In of case of retroactive termination, you will be responsible for and agree to pay all accumulated charges.

Any payment that is not received from your insurance after 60 days from the treatment day will be due in full, from you. You will then have to obtain reimbursement directly from your insurance company.

Please understand that we cannot accept responsibility for negotiating disputed claims between you and your insurance company. We will however assist you any way we can.

If you have secondary insurance and you do not present the card/information prior to your scheduled appointment, we reserve the right to not accept it.

Acceptance of Office Polices & Permission to Bill Insurance:

I certify that I, and/or my dependent(s) have insurance coverage with:

Name of Insurance Company:_____ and assign all benefits directly to Somerset Smiles. I understand that I am financially responsible for all charges whether paid for by my insurance or not. I authorize the use of my signature on all insurance claim submissions. Somerset Smiles may use my health information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits. To the best of my knowledge all the information on this form is true and correct.

Signature: _____Date: _____

HIPAA -- Patient consent for Use and Disclosure of Protected Health Information:

✓ With my consent, designated *Somerset Smiles* personnel may use and disclose protected health information about me and/or dependent(s) to carry treatment, insurance, and payment.

✓ With my consent, *Somerset Smiles* personnel may email referrals, X-rays, treatment history, health information, insurance information that is pertinent to my or dependent's care to another physician and/or dentist, general or otherwise, for continued care.

✓ With my consent, *Somerset Smiles* personnel may call my home, cell phone, or work phone provided and leave a message on voicemail or in person in reference to any action that assists Somerset Smiles personnel in carrying out treatment, insurance questions, and payment, such as appointment confirmations, or clinical care.

✓ With my consent, *Somerset Smiles* personnel may mail to my home or other provided address any items that will assist in carrying out treatment and payment; such as, but not limited to, reminder cards and statements.

✓ With my consent, *Somerset Smiles* personnel may contact me via text messaging and/or email that assists Somerset Smiles personnel in carrying out treatment, insurance billing, payment, appointment confirmations, insurance questions, or clinical care.

Consent for treatment:

☐ I authorize *Somerset Smiles* and designated staff members to take x-rays, study models, photographs, and/or other diagnostic aids deemed necessary by the doctors to make a thorough diagnosis of my/or dependents dental treatment needs. Upon such as diagnosis, I authorize *Somerset Smiles* to perform all the recommended treatment mutually agreed upon by the doctor and myself, and to employ such assistance in my treatment as required to provide proper care. I also give permission to receive text messages and e-mails regarding my appointments.

If you wish Dr.'s Katherine King and/or Dr. Jeremy Nissen, or one of their staff members, to speak with a family member or friend regarding your dental health, treatment, insurance, or account, please indicate the name of **ONE** person below. We ask that you appoint one person to reduce confusion and misinformation.

I give Dr.'s Katherine King and Jeremy Nissen and their staff permission to discuss my/or dependents dental health, treatment, insurance, and account with:

_____ Relationship: _____

By signing below, I am consenting to *Somerset Smiles* Use and Disclosure of my Protected Health Information. If I do not sign this consent, *Somerset Smiles* may decline to provide treatment to me and/or dependents, forward insurance claims on my/dependents behalf.

Acknowledgement of Receipt of Notice of Privacy Practices.

I have been presented a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I understand that my signature below is authorization for the following:

- ✓ I have read and agreed to the office policies of Somerset Smiles and have received a copy.
- ✓ Consent for treatment for myself and/or dependents.
- ✓ HIPPA Consent for Use and Disclosure of Protected Health Information.
- ✓ Consent to speak to a family member or friend
- ✓ Consent to receive e-mails and text messages.

I have read and agreed to the above written office policies of *Somerset Smiles, office of Dr.'s Katherine King and Jeremy Nissen*, and have received a copy.

Signature: Date: