Diane Jenkins Periodontics
Dental Appointment Agreement

Our goal is to help our patients achieve and maintain good oral health for a lifetime. In order to reach this goal it is important for patients to make every effort to keep their scheduled dental appointments. Broken appointments also result in unproductive time that our doctors or hygienists could have used to treat other patients who are awaiting an appointment.

Broken Appointments

Our dental team understands that sometimes situations arise that require you to reschedule or cancel an appointment. However; if you miss or cancel your appointment within 24 hours of the scheduled appointment it is considered a Broken Appointment and a fee of $35 will apply.
You may schedule another appointment at any time; however the Broken Appointment fee will be due at the time of the rescheduled appointment as well as any patient portion due that day.

If three Broken Appointments occur within a two year period, a non-refundable deposit in the amount of $100 will be required upfront before scheduling appointments. After completing three consecutive appointments the $100 deposit will no longer be required.
Any patient or family with a long term history of Broken Appointments may be dismissed from the practice at the discretion of the Practice Manager and affiliated doctor(s).
I understand the Dental Appointment Agreement and agree to follow the terms of the Broken Appointment Policy.

_____

Patient Name (please print) Date

_____

Patient or Guardian Signature

Diane Jenkins Periodontics
HIPAA

Acknowledgment of Receipt of Notice of Privacy Policy
Diane Jenkins Periodontics
110-A Hospital Drive
Simpsonville, SC 29681

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and dentists/physician certifications.

I acknowledge that I have received notice of the availability of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office has the rights to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name _____ Signature _____

Relationship _____ Date _____
(If Parent or Legal Guardian)

Office Use Only

I attempted to obtain patient's signature in acknowledgment of having received notice of the availability of Privacy Policies of this office, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____