Ledgeview
DENTAL CARE

Dr. Cole Stockheimer, DDS
Ph: (920) 983-3800
2225 Kaftan Way
De Pere, WI 54115
info@ledgeviewdental.com

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available at the front desk, at www.ledgeview dental.com, or by contacting the office manager.

This information is made available on request by a patient.

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

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices):

- ▲ For medical treatment
- ▲ To obtain payment for our services
- ▲ In emergency situations
- ▲ To run our Practice more efficiently and ensure all our patients receive quality care
- ▲ For workers' compensation programs
- ▲ To avert a serious threat to health or safety
- ▲ For appointment and patient recall
- ▲ In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must besubmitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- ▲ The right to inspect and copy
- ▲ The right to amend
- ▲ The right to an accounting of disclosures
- ▲ The right to request restrictions
- ▲ The right to a paper copy of this notice
- ▲ The right to request confidential communications

For more information about these rights please see the detailed Notice of Privacy Practices which may be obtained from the front desk, our office manager, or www.ledgeviewdental.com.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I have received a copy of Ledgeview Dental Care's Notice of Privacy Practices.

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Representative
_____	_____
Parent/Guardian or Personal Representative	Parent/Guardian or Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

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RESPONSIBILITY FOR PAYMENT

PATIENT NAME: _____

I agree to be and am fully responsible for total payment of services performed including any amounts not covered by any health, dental, or prepayment program I may have.

I understand that the policy of Ledgeview Dental Care is that the parent who requests treatment and/or presents a minor child for treatment is responsible for all fees for services rendered. In case of divorce, any arrangements made through a divorce agreement are strictly between the parents and do not involve the clinic.

I understand clinic bills are due and payable within 90 days, regardless of insurance coverage and that a finance charge of 1% per month (annual rate 12%) will be applied to any amount due over 90 days. I understand my coverage and benefits is a contract between the policyholder and the insurance company. In the event the insurance company is slow to pay; reduces payment because in their estimation the charges are over usual and customary; or for some reason disallows the claim, I understand payment of the account is my responsibility. (IF INSURED) I authorize the release of medical records and images requested by my insurance company for the purpose of determining pre-treatment estimates and precertification of payment of insurance benefits. I authorize payment directly to Ledgeview Dental Care. A copy of this authorization shall be as valid as the original.

Collection Placement Policy: I understand that I will be responsible for any and all collection agency fees up to 33.33% of the principal balance amount placed with the collection agency *(accrued interest will be removed)*. In the event the collection agency seeks legal action for collection on my account, I will also be responsible for any and all fees associated with court costs, garnishments, and/or attorney fees. I consent to jurisdiction and venue in Brown County, WI for claims or actions arising under or related to this contract.

COLLECTION AGENCY PLACEMENT POLICY:

You are financially responsible for the timely payment of your outstanding bill per our payment policies. You will be responsible for any and all collection agency fees up to 30% of the amount placed with the collection agency. In the event we seek legal action for collection on your account, you will also be responsible for any and all fees associated with court costs, garnishments, and/or attorney fees.

_____ _____

Signature of Patient or Parent/Guardian Requesting Care Date