ANIMAS PEDIATRIC DENTAL GROUP, P.C.

www.animaspediatricdentistry.com

2650 E. Pinon Frontage Rd. Bldg. 200 • Farmington, NM 87402 • (505)599-9359 • Fax: (505)599-8177

LAWRENCE SUAZO, D.D.S. KRISTIN MURPHY, D.M.D.

FINANCIAL AGREEMENT

Print Patient's Name:_____Date:_____

Print Parent/Guardian Name:_____

Our policy is to receive payment for services at the time they are rendered. If you have dental insurance, we will bill your insurance company as a courtesy. However, the responsible party is obligated to pay their deductible and any co-pay portion at the time of service, and for any charges that are only partially paid or that are denied by your insurance company.

I HAVE DENTAL INSURANCE and/or MEDICAID:

Initial:_____

I realize that my insurance benefits can only be estimated, and that not all insurance companies pay 100%. I understand that I am responsible for all costs not paid by my insurance company within 60 days.

I understand that my insurance company has an obligation to me, not to the Doctor. If no payment has been received within 60 days, I understand that interest will begin to accrue at 1.5% per month (18% per year), and that I am responsible for any interest and billing charges applied to my bill.

I DO NOT HAVE DENTAL INSURANCE:

Initial:_____

I will pay for services rendered at the time of service, in full.

NOTE FOR ALL PATIENTS:

I agree to pay the collection fees, attorney's fee, and all other associated costs for collection should this account be turned over for collection. If this account is more than 60 days past due, dental treatment will be delayed or discontinued until full payment is made.

I have read and understand the above information. I consent that my signature may be kept on file for submitting insurance claims for the above named patient(s).

_____ _____

Signature of Patient or Parent/Guardian **Printed** Name of Parent/Guardian

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Failed/Broken Appointment Policy

Effective immediately, each family will be allowed one failed or broken appointment ("no-show" or cancellation without a 24-hour notice) per year. ***Any additional broken appointments will result in a charge of $30.00 per broken appointment.*** If your children were scheduled on the same day and appointments are failed, children shall then be scheduled one at a time. Payment for failed appointments must be received **before** treatment will continue. Failure to comply will result in termination of the doctor/patient relationship.

We regret implementing this policy, but we believe this will help many of our patients to receive care in a timelier manner. Thank you for understanding.

Attention Medicaid Clients

If you have any type of Medicaid insurance as your primary coverage, ***any failed appointments will result in termination of the doctor/patient relationship for 12 months from the date of dismissal.*** Medicaid insurance does not allow us to bill for broken appointments.

I understand the above policy by signing below:

_____ _____

Signature Date

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Date: _____

Patient Name:_____

DOB: _____

My child IS _____ or IS NOT _____ covered under New Mexico Medicaid. I agree to inform Animas Pediatric Dental Group if my child/children are ever covered by New Mexico Medicaid.

_____

Parent's Signature

_____

Print Name

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____ have read and acknowledge this office's Notice of Privacy Practices.

_____

Parent/ Legal Guardian's Signature

Date: _____

Names of children: _____

_____

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)

_____

_____