Arizona Pediatric Dentistry

4145 N. 108 Ave.

Phoenix, AZ 85037

(P) 623-344-2000

(F) 623-344-2007

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ____________________ Print Name: _________________________________

I acknowledge that I have read and understand the below document.

Signature: ____

Shashi Kapur D.D.S
Henry Martinez D.M.D
Mukul Dave D.M.D
Jean Lewis D.M.D
David Ember D.D.S
Nezahet Multu D.M.D

HIPAA PRIVACY STATEMENT

I understand that under the Health Insurance Portability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information.

I understand that this information can and will be used to: 1) Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2) Obtain payment from third-party payers.

I understand that I may request in writing that I may restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but is bound to them if it does agree. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

____
Signature   Date

WELCOME TO OUR PRACTICE

As a service to our patients, we are happy to submit your dental claims to your insurance carrier. Many dentists do not offer this service, and the patients must pay in full at the time of service and take care of their own insurance paperwork.

We try as best we can to **ESTIMATE** what your insurance company will pay us on each claim we submit, and then collect what we believe is your portion at the time of service.

We deal with literally hundreds of insurance companies that represent hundreds of employers, each with their own separate policies. It is impossible to know all limitations of each and every policy our many patients have. In addition, many insurance companies will not release information to the doctor's office concerning their policies and benefits, and *no insurance company guarantees payment of any claim!!*

Therefore should there be a discrepancy between what we have estimated your portion to be and what the insurance company pays us, this amount *becomes your responsibility* to remit to the doctor.

Thank you for your understanding in this matter.

APPOINTMENT POLICY

We schedule our dental appointments very carefully to assure all of our patients are seen promptly, and sufficient time is allowed for each procedure. We do this because we value and respect our patient's time and desire to provide the best treatment possible. In order to remain on schedule, we request that you arrive on time for your appointments.

Occasionally, emergencies arise which may cause us to run over into your appointment. Every effort will be made to inform you of this, if this situation arises. We appreciate your understanding, as someday you or a family member may be in need of emergency dental care.

24-HOUR NOTIFICATION IS REQUIRED TO AVOID A CANCELLATION CHARGE. THE MINIMUM FEE IS $50.00 FOR TIME SCHEDULED. When we are not notified a missed appointment means another patient, who could have been seen. **WE NEED TO VERBALLY CONFIRM ALL APPOINTMENTS THE DAY BEFORE, IF NOT THEY WILL BE CANCELLED.** Please always inform us of any telephone number so we can always communicate with you accordingly.

Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance, we will assist you be billing your claim for benefits. We need your assistance, and your understanding of our financial policy.

Payment for services is due at the time of services are rendered, unless our staff has approved payment arrangements in advance.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, please keep in mind that:

1. You, the patient/insured, are ultimately responsible for your bill

2. Your insurance is a contract between you, your employer, and the insurance company.

3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. I.E. sedation, analgesia, nitrous oxide, ect.

We must emphasize that as a dental provider, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all our charges are your responsibilities from the date of services are rendered. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

A $25.00 charge will be applied to your account for checks that are returned for insufficient funds. A $75.00 charge will be added to account balances over 60 days when transferred to an outside agency for collection.

If a referral is required and you fail to bring one, you will be responsible for the bill.

If you have any questions about the above information, please do not hesitate to ask us. We are here to help.

I have read the above financial policy for Arizona Pediatric Dentistry and Orthodontics L.L.C. and understand that I am responsible for all accrued charges including those charges, which my insurance company may or may not cover at the level, anticipated. Additionally, I understand that should my insurance company delay payment past 30 days, I will be billed and be responsible for the entire balance.

CONSENT

The undersigned, with prior approval, hereby authorizes Arizona Pediatric Dentistry and Orthodontics L.L.C. to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with Dental Treatment.

FEES FOR SERVICES RENDERED ARE PAYABLE UPON CONCLUSION OF EACH APPOINTMENT!!!

ASSIGNMENT AND RELEASE

I, undersigned, I have insurance coverage and assign directly to Arizona Pediatric Dentistry and Orthodontics L.L.C., all dental benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. Additional charges will be added for returned checks and accounts sent for collection.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.