ABC Dentistry for Children

James R Michaud D.D.S M.S.
Richard N. Michaud D.D.S
J. Braden Michaud D.D.S
Harsha Santiago D.M.D
Recognized Specialist by the
American Dental Association

Thank you for being a valued patient of **ABC Dentistry for Children**. *Please take a moment to read and sign our financial and office policies.*

PRIVACY PRACTICES ACKNOWLEDGEMENT

Privacy Notice Amendment September 2013

I have had the opportunity to read the "N**OTICE OF PRIVACY PRACTICES**" for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use on my Personal Health Information.

SCHEDULING
Our office strives to schedule one dentist to complete all of your treatment. Due to emergencies and coordination of doctors and staff at our 3 locations, this course may not always be possible. If you wish to see a specific dentist for your appointment, please let us know.

Delinquent Accounts
- Account balances should be paid within 30 days of the account statement to avoid a $20 billing fee.
- There will be a service fee for any check returned from our financial institution.
- Financial responsibility: I further agree to pay all finance charges, collection cost, attorney's fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

Cancellation of Appointments/No Show
Patient satisfaction is very important to us and we try to schedule appointments in a timely matter. When a patient does not show for a scheduled appointment (no show), it creates an unused slot that could have been used for another patient who possibly is in great need. Therefore it is very important that you call to cancel your appointment.
- If for any reason you need to cancel an appointment, please notify our office no later than 24 hours before the scheduled day.
- On your second no show occurrence, there may be a $25 charge to your account for a missed routine cleaning and a $50 charge for a missed work appointment.

_____ _____
Signature Date

_____ _____
Printed Name Witness

2363 E Baseline Rd
Gilbert, AZ 85234
(480) 558-1400

21321 E Ocotillo Rd., Ste. 109
Queen Creek, AZ 85142
(480) 655-5333

10720 E Southern Ave., Ste. 115
Mesa, AZ 85209
(480) 558-9713

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Insurance/Financial Policies

We accept most insurance plans. These plans may have a co-payment or deductible. Payment plans may be arranged with the billing department.

I, _____understand that services rendered by ABC Dentistry for Children are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to ABC Dentistry for Children and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If I have questions regarding coverage, I understand I can receive a "pre-estimate" from my insurance company and understand that this is not a guarantee of payment. Insurance companies have their own rules for determining benefits and it is ultimately my responsibility to understand which benefits fall under my plan.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me whether by check, draft or other method, I will forward the payment to ABC Dentistry for Children within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____

Policy Holder/Parent Signature Date

_____ _____

Printed Name Witness