FINANCIAL POLICY

1. We are providing a professional service at a reasonable fee. Payment is expected at the time of service. Payment may be made in the following ways:
   Cash Check Visa/MasterCard
   A selection of independent financial services

2. New patients and emergency patients are required to pay for their first visit at the time of service.

3. The contractual liability for insurance companies in New Mexico is to the patient, with the patient being responsible to the Doctor. We will file your insurance as a service to you.

4. Insurance co-payments are made as follows:
   20% co-pay = 30% payment at time of service.

   30% co-pay = 40% payment at time of service.

   50% co-pay = 60% payment at time of service.
   This system is due to insurance company limitations, and usual and customary fee programs.

5. MONTHLY PAYMENT PROGRAM: We have contracted with an independent financial company to provide a monthly payment program to our patients. This service allows you to make small monthly payments on larger treatment plans.

6. DISCOUNTS: Our policy is not to discount for any reason. **This allows our practice to keep our fees for everyone as low as possible.**

7. We will file your insurance claim at no charge, as a service to you. All Insurance balances will become the patient's responsibility if insurance falls short, and or does not pay within 60 days.

8. Arrangements must be made on all past due balances prior to seeing a provider.

9. We do not invoice patients, all balances must be paid at the time of service this allows us to keep our fees as low as possible.

10. All over due collection costs will be paid for by the patient.

I understand, and agree to follow all the above information.

Signed _____ **Date** _____

Dwight D. Howard, D.D.S.

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Practice Name: _____

Address: _____

City/State/Zip _____