

**Pearly Whites Dental Office  
2200 Grande Blvd Ste. A  
Rio Rancho, NM 87124  
505-891-1500**

**OFFICE POLICY**

Thank you for choosing Pearly Whites Dental for your dental care. We are dedicated to helping you maintain healthy teeth and gums. Our office policies, procedures and financial statements are designed to keep you informed and up to date prior to treatment. All of our patients must complete and sign our New Patient packet; please review the forms and sign each form after you have read it.

Pearly Whites Dental Hygiene Clinic, Inc., dba Pearly Whites Dental is owned and operated by Shirley Profazi, RDH. Dentists are independent contractors of Pearly Whites Dental Hygiene Clinic, Inc.

**Appointment Policy**

If you are unable to keep a scheduled appointment, please notify Pearly Whites Dental within 48 hours of the appointment. If an emergency arises, as they do often, Pearly Whites Dental requires notification that the appointment will be missed and rescheduled. *If 2 appointments are missed without notice, the patient will be dismissed from the practice and x-rays will be forwarded to the dentist of choice. If the contact phone number given to Pearly Whites Dental is disconnected and the appointment is unable to be confirmed, the appointment will be cancelled. It will then be the patient's responsibility to reschedule the appointment.*

**Minor Patients**

An adult parent or guardian must accompany all patients under the age of 18 for all procedures.

**Returned Checks**

Checks that are not honored by your bank ("bounced" or "stop-payment") will accrue a \$25 service charge. If the check value and fees are not paid by alternative means within 30 days, a collection service will be notified.

**Updating Information**

It is the responsibility of the patient to inform Pearly Whites Dental of any changes in personal information or any changes in insurance coverage. Pearly Whites Dental is HIPPA compliant in accordance with the federal law protecting you and your family's information.

Patient (or Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_

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**STATEMENT OF FINANCIAL RESPONSIBILITY**

Initial \_\_\_\_\_

As a courtesy to our patients, Pearly Whites Dental will file the initial claim to the insurance company provided by the patient or responsible party. The account remains the responsibility of the patient or the responsible party. Once the insurance company is billed, Pearly Whites Dental will set aside the estimated portion due from the insurance company for 30 days. The patient's portion is to be paid at the time of service. If the insurance company does not remit payment within 30 days, the balance will be due in full. Should you receive any payments from the insurance company for services rendered, please remit those payments to Pearly Whites Dental Office. If payments received by Pearly Whites Dental are in excess of the estimated balance, it will promptly be refunded to you or to the insurance carrier, as appropriate.

**Please note that copays are estimates only. Your dental insurance may pay more or less than what we estimate. Once the insurance payment has been received any remaining balance will be the responsibility of the insured. Treatment plans provide only an estimate of your care.**

**For Medicaid, Pearly Whites Dental will bill all services directly. No payment other than applicable co-payments will be expected from the patient. If services are denied for any reason, patient will be held responsible for the entire amount. Please note that proof of Medicaid eligibility is required at the time of service. *It is the responsibility of the patient to know their eligibility status.***

**Assignment of Insurance Benefits**

Initial \_\_\_\_\_

I hereby authorize direct payment to Pearly Whites Dental of any insurance benefits otherwise payable to me or on my behalf for services performed by any Pearly Whites Dental dentist. I understand that my insurance is billed as a courtesy and I am financially responsible for all charges not covered by this assignment of benefits. **Insurance benefits are a contract between the patient and the insurance company not between the insurance company and Pearly Whites Dental.**

**Authorization for Release of Information**

Initial \_\_\_\_\_

I authorize Pearly Whites Dental to release information concerning my care and treatment as may be required by third party payers for the purpose of processing claim payment. I authorize Pearly Whites Dental to submit claims for benefits, services rendered, or pretreatment authorizations without obtaining my signature on each claim to be submitted.

**Credit Policy**

Initial \_\_\_\_\_

In the event that my account is unpaid after 90 days, I understand it will be placed with a collection agency. I agree to be responsible for the collection fees, reasonable attorney fees and court costs. **If the account is placed with a collection agency, the patient will be dismissed from the practice.**

Patient (or Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_