



CENTER FOR
DENTAL SLEEP MEDICINE & TMJ
OF NEW MEXICO

☎ : 505.433.2107
📠 : 505.508.2674
🌐 : www.centersleeptmj.com
✉ : smile@centersleeptmj.com

Patients name: _____

Appointment date: _____

Dear new patient:

Welcome to our practice and thank you for giving us the opportunity to evaluate and manage your Sleep Apnea and TMJ needs. For your convenience we are enclosing some forms and information to prepare you for your first visit.

Please complete the Registration Form and Medical Questionnaire and read and sign the Financial Policy. In addition to those forms, you will need to bring your medical insurance card(s).

Here is a review of all the things you will need to make your first visit go smoothly. We hope you find this helpful.

First visit checklist:

- Registration Form Completed
- Medical Questionnaire Completed
- Financial Policy Read and Signed
- Medical Insurance Card(s)

Like most health care practices, it is imperative that you arrive on time for your appointment. If you need to reschedule, please give 24 hours notice. If you have any other questions please do not hesitate to contact us at (505) 433-2107. Thank you again for this opportunity. We look forward to meeting you.

Sincerely,

Kinnari Jariwala, DDS

Today's Date: _____

Patient's First Name: _____ MI: _____ Last Name: _____

Responsible Party (if someone other than patient): _____

Address: _____ Apt # _____ State: _____ Zip: _____

Home Phone # _____ Cell # _____ Work # _____

Okay to leave message regarding health information on voicemail? If yes, initial: _____

Patient's SS#: _____ DOB: _____ Age: _____ Sex: _____

Marital Status: _____ E-Mail Address: _____

If patient 18 years or over and insured by parent: Is patient a student? Yes No

If patient is a minor:

Parent's or Guardian's full name: _____ Relationship: _____

Family Dentist: _____ Dentist's Phone: _____

Family Physician: _____ Physician's Phone: _____

Referred by: _____ Phone: _____

Please tell us about your insurance coverage. Complete all fields:

MEDICAL INSURANCE

PRIMARY: Name of Insurance Company:

Policy Holder's Name: _____ SSN: _____ DOB: _____

Policy Holder's Employer: _____ ID# _____

Relationship to Patient: _____

SECONDARY: Name of Insurance Company:

Policy Holder's Name: _____ SSN: _____ DOB: _____

Policy Holder's Employer: _____ ID# _____

Relationship to Patient: _____

INJURY OR TRAUMA

Name of Workers Comp Or Auto Ins. Company: _____

Case Worker's Name: _____ Claim#: _____

Phone #: _____ Employer: _____

Date of Injury: _____

MEDICAL QUESTIONNAIRE

NAME: _____ DOB: _____ TODAY'S DATE _____

CHIEF COMPLAINT

- _____ Jaw pain
- _____ Jaw clicking
- _____ Jaw locking
- _____ Limited mouth opening
- _____ Pain when chewing
- _____ Facial pain

- _____ Neck pain
- _____ Headaches
- _____ Migraines
- _____ Ringing in the ears
- _____ Pain in or around ear
- _____ Dizziness

- _____ Frequent heavy snoring
- _____ Fatigue
- _____ Tooth Pain
- Other: _____
- _____
- _____

ALLERGENS

- _____ No Known allergies
- _____ Local anesthetic
- _____ Sleeping pills
- _____ Codeine
- _____ Iodine

- _____ Barbiturates
- _____ Latex
- _____ Aspirin
- _____ Penicillin
- _____ Plastic

- _____ Metal
- _____ Antibiotics
- _____ Sulfa drugs
- _____ Sedatives

MEDICATION

DOSAGE/FREQUENCY

REASON

SURGICAL OPERATIONS

- _____ Appendectomy
- _____ Back surgery
- _____ Ear
- _____ Gallbladder
- _____ Heart surgery

- _____ Hernia repair
- _____ Lung
- _____ Nasal
- _____ Thyroid
- _____ Tonsillectomy

- _____ Uvulectomy
- _____ Periodontal
- Other: _____
- _____

FAMILY HISTORY

- _____ Cancer
- _____ Diabetes
- _____ Heart disease
- _____ High blood pressure

- _____ Obesity
- _____ Sleep disorder
- _____ Stroke
- _____ Thyroid disorder

- _____ Father snores
- _____ Father has sleep apnea
- _____ Mother snores
- _____ Mother has sleep apnea

MEDICAL HISTORY

Acid reflux
 Anemia
 Artherosclerosis
 Arthritis
 Asthma
 Autoimmune disorder
 Bleeding easily

Blood pressure-High
 Blood pressure-Low
 Bruising easily
 Cancer
 Chemotherapy
 Chronic fatigue
 Chronic pain

COPD
 Coronary heart disease
 Current pregnancy
 Depression
 Diabetes
 Difficulty sleeping
 Dizziness
 Emphysema
 Epilepsy

Excessive Daytime
Sleepiness
 Fibromyalgia
 Glaucoma
 Gout
 Heart attack
 Heart murmur
 Heart pacemaker
 Heart valve replacement
 Hemophilia
 Hepatitis
 Hypertension
 Hypoglycemia
 Immune system disorder
 Insomnia
 Ischemic heart disease
(reduced blood supply)
 Kidney problems
 Liver disease
 Meniere's disease
 Mitral valve prolapse
 Mood disorder
 Multiple sclerosis
 Muscular dystrophy
 Nasal allergies
 Neuralgia

Osteoarthritis
 Osteoporosis
 Parkinson's disease
 Prior orthodontic
treatment
 Radiation treatment
 Rheumatic fever
 Rheumatoid arthritis
 Sinus problems
 Sleep apnea
 Stroke
 Tendency for ear infections
 Thyroid disorder
 Tuberculosis
 Tumors
 Urinary disorder
Other: _____

SOCIAL HISTORY

Tobacco Use:

Cigarettes
 Never smoked
 Current smoker
of Packs per day: _____
of years: _____
 Quit smoking
When did you quit?: _____
Other: tobacco
 Pipe Cigar

Alcohol use

None
 Wine
 Beer
 Liquor
Drinks per week: _____
 Snuff Chew

Caffeine intake

None
 Coffee
 Tea
 Soda
Cups per day? _____

SYMPTOMS

JAW PAIN

- ___ Jaw pain - on opening
- ___ Jaw pain - while chewing
- ___ Jaw pain – at rest

JAW SYMPTOMS

- ___ Jaw clicking
- ___ Jaw popping
- ___ Jaw locks closed
- ___ Jaw locks Open
- ___ Teeth grinding
- ___ Teeth clenching

MOUTH AND NOSE RELATED CONDITION

- ___ Burning tongue
- ___ Frequent biting of cheek
- ___ Frequent snoring
- ___ Past history of broken teeth
- ___ Dry mouth

EAR RELATED CONDITIONS

- ___ Buzzing in the ears
- ___ Tinnitus (ringing in the ears)
- ___ Ear pain
- ___ Ear Congestion
- ___ Pain in front of the ear
- ___ Hearing loss
- ___ Pain behind the ear
- ___ Recurrent ear infections

EYE RELATED CONDITIONS

- ___ Blurred vision
- ___ Eye pain
- ___ Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITION

- ___ Back pain
- ___ Chronic sore throat
- ___ Feeling foreign object in throat
- ___ Difficulty in swallowing
- ___ Limited movement of neck
- ___ Neck pain
- ___ Numbness/Tingling (hands/fingers)
- ___ Sciatica
- ___ Scoliosis
- ___ Shoulder pain
- ___ Shoulder stiffness
- ___ Swelling in the neck
- ___ Swollen glands
- ___ Thyroid enlargement
- ___ Tightness in throat
- ___ Chronic sinusitis

What do you believe is the cause of the pain or condition?

- | | | |
|------------------------------|-----------------|-----------------------|
| ___ a motor vehicle accident | ___ a fight | ___ orthodontics |
| ___ a motorcycle accident | ___ a fall | ___ dental procedures |
| ___ a work related incident | ___ an accident | ___ whiplash |
| ___ a playground incident | ___ an illness | Other: _____ |
| ___ an athletic endeavor | ___ an injury | |

When did the pain or condition first occur? _____

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

What other information is important regarding the pain or condition? _____

HISTORY OF TREATMENT

Practitioner's Name

Specialty

Treatment Approximate Date

HEAD PAIN HISTORY

Which side are the headaches worse?

_____ both sides

_____ the left side

_____ the right side

Headache spreads to

_____ the temple

_____ the back of the head

_____ the forehead

Other: _____

SEVERITY ON A SCALE OF 0-10

0=No Pain; 10=Worst Pain Imaginable

_____ Jaw Pain on a 0-10 Pain Scale

_____ Headaches on a 0-10 Pain Scale

_____ Neck Pain on a 0-10 Pain Scale

_____ Facial Pain on a 0-10 Pain Scale

FREQUENCY

_____ Occasional (0-3/mo)

_____ Frequent (3-6/mo)

_____ Constant

DURATION

_____ Seconds

_____ Minutes

_____ Hours

_____ Days

_____ Weeks

When having pain do you experience:

_____ Dizziness

_____ Vomiting

_____ Sensitivity to noise

_____ Nausea

_____ Double vision

_____ Burning

_____ Throbbing

_____ Sensitivity to light (photophobia)

_____ Fatigue

Other: _____

I certify that the medical history information is complete and accurate

Patient Signature: _____ Date: _____



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2023, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in fact. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your medical health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representatives: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare; but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to Food and Drug administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activity; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert serious threat to health or safety; and to comply with workers compensation or similar programs.

Descendants: We may disclose health information about a descendant as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you \$0.25 for each page, and \$30 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation for our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law. We must comply with a request to restrict a disclosure of protected health information to a health point for purposes of carrying out payment or healthcare operations (as defined by HIPAA) if the protected health information pertains solely to a healthcare item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this website. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact officer: Kinnari Jariwala, DDS

Telephone: 505-433-2107

Fax: 505-508-2674

E-mail: smile@centersleeptmj.com

Address: 8311 Saint Pedro Dr. NE Suite 2, Albuquerque, NM 8711



**Acknowledgement of Receipt of
Notice of Privacy Practices (NOPP)**
You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this offices notice of privacy practices.

Print Name: _____

Signature: _____ Date: _____

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify): _____



Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____

I hereby authorize the use and disclosure of individually identifiable medical/dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected HIPAA privacy regulations.

Specific Description of Information to Be Used or Disclosed: Medical and Dental health history, Clinical and Imaging Study Findings, Treatment Plan, Progress Report and Completion of Treatment.

Purpose for Disclosure: To keep your health care providers informed of your treatment.

I authorize the following person(s) to keep the requested use or disclosure of the above health information:
Doctor and Staff at Center for Dental Sleep Medicine & TMJ of NM

Person(s) Receiving My Authorized Information Include (Fill in Names):

- Parent/Spouse/Relative _____
- Referring Provider _____
- Primary Care Doctor _____
- Orthodontist _____
- Other Consultants _____

I understand that I may revoke this authorization at any time by notifying the Center for Dental Sleep Medicine & TMJ of NM in writing. If I choose to do so, my revocation will not affect any actions taken by the Center for Dental Sleep Medicine & TMJ of NM before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I **do not** authorize Dr. Kinnari Jariwala or affiliates to release any medical information.

This Authorization Expires on Continue Indefinitely Effective Only Until _____ (date)

Signature of Patient or Patients Personal Representative

Date _____

If Personal Representative: Print Name: _____

Signature _____ Relationship to Patient _____

For office use only: Copy of signed authorization provided to the individual: Date _____ Initials _____



Financial Policy

We are pleased that you have chosen **Center for Dental Sleep Medicine & TMJ of NM** for the evaluation and management of your Sleep Apnea or TMJ needs. We hope that your experience here will be exceptional. We strive to communicate clearly and effectively with you in all aspects of your care. We have created this policy so that you understand our expectations regarding insurance and payment for services. If you have any questions, please address those to the receptionist or office manager before you sign the acknowledgement.

1. Forms of Payment: Payment for services is expected the same day services are performed. For your convenience, we accept Visa, MasterCard and American Express, in addition to cash, checks, and money orders. You will be responsible for paying a \$25 fee for returned checks. "Care Credit" and "Sunbit" are also available for interest free financing that allows payment over six months. Please ask our front desk staff about these payment options.

2. Covered and Non-covered Services: Appliances are not covered by dental insurance period however some medical policies will cover them if they are prescribed by a physician on your plan. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Insurance Benefits: We will be happy to file your insurance claims as an added service to you. However, it is important that you understand that your insurance company does not share financial responsibility for your bill. Unless you are insured by a federal or state funded program you are responsible for all charges if your insurance company fails to pay.

5. Pre-Authorizations/ Pre-Certifications: We will be happy to attempt to get the service pre-authorized. If the insurance company denies the service, we will notify you. If you have a question concerning your benefits you should direct those to your insurance company.

6. Patient Portion vs. Insurance Portion: Before a service is performed, we will attempt to estimate the portion of the service that your insurance company will not cover. We will notify you of that portion either orally or in writing and you will be expected to pay your estimated portion on or before the service date. For delivery of appliances, your estimated portion will be due on or before the delivery visit. As mentioned above, the insurance portion is estimated and is never a guarantee of payment even after an authorization has been obtained (except for state and federal funded programs). Ultimately, your bill is your responsibility regardless of insurance benefits.

7. Denied or Unpaid Insurance Claims: We will do our best to work with your insurance company to receive reimbursement for your services. However, if an insurance company does not remit

payment within 120 days of the service date. For this reason, we encourage you to communicate with your insurance company about your outstanding claims. Additionally, if the insurance company denies payment on a service, and our attempts to appeal the denial fail, you are responsible for the balance. Unfortunately, this sometimes happens even after the service has been pre-authorized.

8. Financial Arrangements: In the event of financial hardship, optional payment arrangements may be discussed with the office staff before the planned date of the procedure or surgery. Since the doctor's main focus is on your health and treatment, they are unable to discuss fees or payment arrangements with you. If alternate arrangements are not requested and agreed upon before the date of the procedure, full payment of the patient's estimated portion will be due, as detailed in this policy.

9. Cancellation of Appointments: In fairness to other patients and the doctor, we require 24 hours notice if you must cancel an appointment. We reserve the right to charge a \$50 fee for missed appointments without 24 hour notification.

Thank you again for entrusting us with your care. If you have any questions about this policy or something not addressed in the policy, do not hesitate to ask a member of our office staff.

ASSIGNMENT OF INSURANCE BENEFITS I hereby assign all dental and medical benefits to **Center for Dental Sleep Medicine & TMJ of NM** and authorize the release of medical information to insurance company(s), when requested or necessary. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original.

AGREEMENT WITH FINANCIAL POLICY I will pay for services rendered on the date of service. I have read and agree to the above financial policy. I understand that I am ultimately responsible for all fees for services provided to me.

THIS IS NOT A CONTRACT NOR AN AGREEMENT TO SEEK TREATMENT

Patient's Name (Printed): _____

Signature: _____ **Date** _____



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