



DANIEL F. GALINDO, D.D.S., P.C.

Board Certified by the American Board of Prosthodontics

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

Welcome to Dr. Daniel F. Galindo's specialty practice in prosthodontics. We hope this information will answer some of your questions about our office's policies and financial arrangements. These are a very important part of your treatment. We require you to read and sign this document prior to any dental treatment is started.

Financial Arrangements

It is our policy to completely examine and discuss treatment plans with all patients or guardians before dental treatment is started. A complete estimate of fees and method of payment will be discussed after your initial clinical exam during the treatment plan conference. As a result of the amount of time that we invest in your treatment, along with material and overhead costs, full payment is expected at each appointment, in the form of cash, check, credit (MasterCard, Visa, American Express and Discover) or debit card. It is our policy to receive one half of the quoted fee in advance of treatment. The second and final payment is required prior to the placement of the final restorations. Interest charges (18% per annum) are placed on the account if payment is sixty days past due.

Dental Insurance

As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment, and we will do so without charge. However, in order to avoid misunderstandings, please read carefully and understand the following policies in regard to dental insurance benefits. Our professional treatment is rendered to you, not the insurance company; you are directly responsible to us for the obligation of payment of treatment. Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer. Our office is not responsible for the accuracy of co-payments, deductibles or other insurance benefits. We will do our best to see that you receive your full benefits within the structure of your particular dental plan. However, ultimate responsibility for payment is yours and your financial arrangements must be defined before dental treatment can begin.

Appointment Policy

The complex nature of your dental treatment requires a series of appointments with explicit amounts of time periods between them to allow us to complete your treatment to the high standards that we constantly strive to achieve. Once your appointment schedule is determined, it is then coordinated with the dental laboratory in order to achieve a smooth progression of your treatment. If you constantly change the dates of your appointments, this affects the laboratory schedule of your treatment, and in this event we may not be able to complete your treatment on a specific date.

Should you need to change a scheduled appointment, we would appreciate the courtesy of being informed at least 48 hours in advance.

AESTHETIC DENTISTRY · CROWN AND BRIDGE · COMPLETE DENTURES · IMPLANT DENTISTRY · RECONSTRUCTIVE DENTISTRY

□ 5533 E. BELL ROAD, SUITE 120 · SCOTTSDALE, AZ 85254 · TELEPHONE: 602.441.5529
□ 8877 W. UNION HILLS DR., SUITE 100 · PEORIA, AZ 85382 · TELEPHONE: 623.231.9133
F: 602.441.5970 | E: TEAM@GALINDOPROSTHODONTICS.COM | WWW.GALINDOPROSTHODONTICS.COM



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Agreement

I accept full financial responsibility for the services rendered to me at Daniel F. Galindo, D.D.S., P.C. and understand that I am responsible for my dental cost, regardless of any insurance coverage. I have read, understood and agreed to the office policies and financial arrangements above.

_____ Date: _____ Reviewed _____
Signature of patient, parent or guardian



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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name: _____ SSN: _____
Address: _____ Telephone: _____

Section B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: Before signing this form, you will consent to our disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practice as described in our notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

- Ana M. Galindo **Telephone:** 602.441.5529 **Address:** 5533 E. Bell Road, Suite 120; Scottsdale AZ 85254
- Ana M. Galindo **Telephone:** 623.236.9133 **Address:** 8877 W. Union Hills Dr., Suite 100; Peoria AZ 85382

Right to Revoke: You will always have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand revocations of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: I, _____, have had full opportunity to read and consider the contents of this Consent form and your notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment, activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

Date: _____

For 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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

