Welcome to New Heights Dental
Michael A. Sweeney D.M.D.

4111 Barbara Loop, Suite D-2 * Rio Rancho, NM * 87124

Thank you for choosing our team for your dental care. We are looking forward to helping you maintain good oral health, and appreciate the trust you have placed in us. Our office policies and procedures are designed to keep you informed; we do not want finances to be an issue for our patients. We ask that all of our patients read and sign this form to avoid any misunderstandings of the options available.

DENTAL INSURANCE: We emphasize that as dental care providers our relationship is with you and not your insurance company. As a courtesy to you we will complete and file your insurance claim to the insurance company. Your deductible and estimated co-payment (the amount not covered by your insurance) is due at the time treatment is provided

PAYMENT OPTIONS: We accept Visa, MasterCard, Discover, AMX, cash and checks. We also accept Care Credit upon approval.

CONTINUING CARE MEMBERSHIP: If you are uninsured ask us for details regarding our Continuing Care Program.

MINOR PATIENTS: An adult parent or guardian must accompany minor patients. Please do not leave your children unattended. The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment may be denied unless charges have been pre-paid in advance. We make every effort to preauthorize dental treatment ahead of time to avoid any surprises.

BROKEN OR MISSED APPOINTMENTS: Our practice may charge you a **$50.00** fee for appointments missed or broken without proper 48 hour weekday notice. We understand that emergencies occur. However, we want to be able to make the appointment available for other patients.

RETURNED CHECKS: A fee of $35.00 will be charged for any returned checks.

ASSIGNMENT OF DENTAL BENEFITS: I assign directly to Dr. Sweeney all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not covered by my insurance. I authorize the use of my signature on all insurance submissions. I authorize Dr. Sweeney's practice to use my health care information and disclose such information to my insurance company(ies), for the purpose of obtaining payment for services rendered, and for determining insurance benefits payable for related services.

By signing below I agree that I have read the policies and understand and agree to them.

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Signature of Patient or Responsible Party Date