Copper Canyon Family Dentistry
Dr. Seth J. Stockton, DMD and Dr. Erin E. Stockton, DMD
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Albuquerque, NM 87109
(505) 830-9081

FINANCIAL RESPONSIBILITY CONTRACT

In agreeing to be responsible for your dental care, Copper Canyon Family Dentistry, requires that you be responsible for your ***financial obligation*** to us.

Please read each paragraph and sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18 years of age), your parent or legal guardian must accept financial responsibility on your behalf.

1. I agree to pay for all services provided to me by Copper Canyon Family Dentistry and the staff **at the time services are rendered**, unless those services are covered by my insurance company.

2. I understand that my insurance company may require that I pay co-payments, co-insurance and/or deductibles. I agree to pay these in full at the time services are rendered.

3. I understand and agree that if, after 45 days of billing and/or insurance is filed, my contracted insurance has not paid Copper Canyon Family Dentistry, I may request that the office contact my insurance to find out why they have not paid on my outstanding claim(s). I may also be required to contact my insurance company myself to ask for resolution of the unpaid claim(s).

4. I understand and agree that if, after 45 days of billing, whether my non-contracted insurance company has made a payment or not on my account, I am responsible for the total balance due on that account.

5. I understand and agree that if a balance on my account remains unpaid after 45 days, that account may be sent to a collection agency. I will then be responsible for any amount due plus cost of collection, including, but not limited to:

    - All collection expenses charged by the collection agency;
    - Court costs;
    - Attorneys' fees; and
    - Any discounts I may have received on my account will be reversed.

6. If my account is sent to a collection agency, Copper Canyon Family Dentistry may require me to permanently seek further dental care elsewhere.

7. I am aware that there is a $50 cancellation/no show fee that will be applied to my account if I do not show up to a scheduled appointment or do not give at least 24 hour notice.

SIGNATURE (Patient or Parent/Guardian of Minor):_____Date:_____