

Broadmoor Dental Office Policy

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Signature: I certify that I, _____, (or my dependent) have dental insurance coverage and assign directly to Broadmoor Dental all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Patients without dental insurance coverage understand that they are responsible for 100% of the fees on or before the day of treatment.

Payments: Pre-payment is required for all prescribed/accepted dental treatment. Collecting in advance allows our office to reserve your time with the doctor. When you prepay for treatment you are agreeing to take care of your dental needs. Money that you prepay/pay for needed dental treatment will not be refunded. However, if you are refusing treatment and insist on a refund, you will be responsible for all charges incurred and may be assessed a cancellation fee. We have several payment methods we offer to our patients to assist them in taking care of their dental needs. If you use one of our finance companies and decide to change the terms of your account you will be responsible for all charges incurred. A \$25.00 fee will be applied for any returned checks. A photo id is now required for all non-cash payments.

Billing Policy: As a courtesy, we will bill your insurance company for services rendered. Once payment is received from the insurance company, you will receive ONE patient statement for the balance due. It is expected that your payment will be made in 10 (ten) days. If your payment is not received, it will be considered past due and may be sent to collections. Thank you. We reserve the right to impose a service charge of 2 % per month (18% per annum) on the unpaid balance on all accounts exceeding 30 days, unless previously written financial arrangements have been made. If an account is turned over to a collection agency and/or attorney for collection, the account holder will be responsible for all attorney and/or collection fees. Any balance that is ninety days (90) past due is subject to being sent for collection.

Unpaid Insurance Benefits: I understand that all dental services furnished, whether the patient has insurance or not, are charged directly to the patient and that he or she is personally responsible for payment of all dental services. If an insurance company has not paid a claim after sixty days (60) of it being submitted, the office will require that the patient pay the account in full. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. A photo id is now required with all insurance cards. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Treatment Estimates: The office routinely provides our patient with an estimate of cost for prescribed treatment. Since your insurance determines the benefits payable for services the office cannot be held responsible for 100% accuracy on any estimate for treatment.

Alternate Benefits: I understand that most insurance companies downgrade coverage on non-metal restorations and I agree to the adjusted fees for upgraded materials.

Condition of Treatment: As a condition of treatment by this office, financial arrangements must be made in advance, and financial responsibility (whether insurance remittance or patient portion) on the part of each patient is determined before treatment. All emergency dental services, or any dental service performed without financial arrangements, must be paid in full at the time services are performed.

Missed or Broken Appointments: Rescheduling an appointment may be done up to 48 hours prior to your scheduled appointment without expense. You will be assessed a \$50.00 fee for the second missed appointment, and a \$100.00 for the third missed appointment, after which the practice reserves the right to dismiss patients due to repeated rescheduling or missed appointments.

Broadmoor Dental reserves the right to update this Office Policy at any time without notification.

My signature verifies that I have read, understood, and accepted the policies described above, and further grant you or your assignee permission to telephone me at home or at my work to discuss matters related to this form.

Signature: _____

Date: _____