.BRECKENRIDGE DENTAL CARE FINANCIAL POLICY FOR PATIENT CARE SERVICES

To help provide the most efficient and reasonable health care services, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have accurate and complete information. The balance due is still your responsibility if we have not received payment from the insurance company within 30 days.

If you have insurance and we file with your carrier, we require payment of balances which are deemed your responsibility (co-payments, deductibles, co-insurance) at the time the service is received. We ask that you please contact your insurance company if your claim has not been paid within 30 days.

If you do not have insurance, you will be considered a "Self Pay" patient, and payment is due in full at the time of service. This will help reduce billing and operational costs which directly affect our fees.

Patient "no shows" and cancellations are a tremendous loss for a practice. Time has been reserved for your dental care. Please help our office reduce losses by canceling with at least a 24 hour notice or a $50.00 cancellation fee is incurred for this reserved time.

All appointments must be confirmed by patient/or responsible party. This may be done by choice of text, phone call or Email confirmation. If appointment is not confirmed, it will be assumed you will not be keeping this reserved time and the appointment will be cancelled.

We ask that you read this policy and aid us in keeping our costs down by ensuring that we are able to be reimbursed for our services on a timely basis. We welcome the opportunity to discuss any aspect of our financial policy.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up dated.
2. Make payment at the time of service for the entire balance if you are a "Self Pay" patient, or for the amount of any deductible, copayment or coinsurance.
3. Discuss your account balance only with the office personnel and not with the dentist(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with our office personnel for any accounting questions you have. If they cannot answer your questions to your satisfaction, please contact the office manager.
4. Please be prepared to present your insurance card upon signing in.
5. Understand that we, from time to time, may verify insurance benefits on your behalf. **Please be aware that we cannot be responsible for misinformation received from your insurance company**. Insurance companies have a disclaimer for all callers stating that the benefits given over the phone are only an estimate and that the benefits are not determined until the actual claim is paid. Therefore, it is not possible for us to guarantee any type of coverage or benefit on your behalf.
6. Understand that you will be charged .5% month finance charge for any balances over 60 days old.
7. There will be a $50.00 charge for all appointment cancelled without 24 hours notice or missed appointments.

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Patient Signature Date

_____ _____

Patient Name (Please Print) Date of Birth