

**BROADWAY SMILES**  
**Halek & Rathburn Partnership**  
**Financial Policy**

Welcome to our office! We are delighted that you have chosen our dental practice to guide you in maintaining excellent oral health. It is our mission to provide comprehensive, technically superior dental care in a safe, comfortable and professional environment. In return, we ask for your commitment to your dental health. Please feel free to ask any questions at any time to clarify any procedure, treatment plan or payment expectation.

**No Insurance Coverage**

Payment is due at the time of service, unless financial arrangements are made with the front office personnel. Any service under \$300.00 is due in full at the time of service. Any individual 18 years of age and older is accountable for payment at the time of service. Through CareCredit, we offer monthly payment plans with approved credit.

**Insurance**

We do encourage you to become familiar with your policy's exclusions, deductibles and required co-payments. As a courtesy to our patients, we will provide the processing of your primary coverage insurance claims. Insurance is a contract between you and your insurance company. We are not a party to this contract. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits and eligibility. **Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient/responsible party and that he or she is personally responsible for payment of all dental services.** We cannot file a claim to your insurance company unless you give us your insurance information. At your first visit if we do not have the insurance information, we will give you a statement to submit to your insurance company and payment will be required at the time of service. All patients will be expected to pay all estimated co-pays, deductibles and non-covered portions of dental procedures at the time of service. We will accept assignment of benefits from your insurance company unless it is a direct reimbursement plan. Then, each person is responsible to pay for the treatment at the time of service. If your insurance company does not respond to the submission of the claim within 90 days, all charges will need to be paid by the patient or responsible party. Secondary insurance claims will be the responsibility of the patient.

**Cancellation Notice and Missed Appointment Fee**

We ask that our patients carefully schedule each appointment. We reserve this appointment time for you and expect that you will arrive on time. If you must change an appointment, **please give us 48 hours notice.** When a patient does not show for or late cancels an appointment, a \$50.00 fee will be charged. Patients with 3 missed appointments and/or late cancellations may be asked to transfer their records to another doctor.

**Returned Checks**

There will be a \$20.00 service charge on all returned checks and additional charges for the cost of collection.

**Past Due Accounts**

The responsible party and/or patient hereby understands that if the account becomes delinquent, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all court costs and attorney fees for collection of all past due amounts owed, plus interest thereon at 18% annum on all such amounts outstanding.

**Divorce**

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Workers Compensation**

We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**Effective Date**

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. If you have insurance benefits, you authorize payment directly to the dental office of the insurance benefits otherwise payable to you.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party's Signature \_\_\_\_\_