BREEZE DENTAL CARE FINANCIAL POLICY

_____ It is your responsibility to notify us If you choose not to have fluoride applied to your child's teeth. Our office provides **fluoride every six months** to all patients under 18 years of age, however some insurance companies only cover it once per year. If your insurance company denies this treatment for any reason the amount will be billed to you.

_____At Breeze Dental Care we pride ourselves on the amount of time we are able to spend with each patient. We are able to spend the additional time with each patient due to accurate and efficient scheduling. (Please keep in mind that emergencies do arise and this may affect your appointment time. We will do our best to inform you if we are running behind.) Due to this we ask that you give at least a **48-hour notice if you do have to change an existing appointment**. Any missed or last minute cancelled appointments will be subject to a minimum of $50.00 missed appointment fee. After 3 missed appointments, we will no longer be able to see you as a patient. At any given time, we may have dental emergencies that arise. Without prior notice from you we cannot accurately schedule them.

Our office has computer software that will contact you to confirm your appointment. We do need to have each appointment confirmed. If you do not confirm though our automated system, please call our office to confirm your appointment directly.

_____ If our office is not filing an insurance claim for you, payment in full is due at the time of service unless prior arrangements have been approved through our billing department.

_____ I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. **I understand that dental insurance is a contract between myself and the insurance company**. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement. If you have any questions regarding your coverage Breeze Dental Care will gladly help answer those questions, but at no time does Breeze Dental Care guarantee any payment or coverage from your insurance company. Any fees that you incur for services rendered are your responsibility, not the responsibility of your insurance company.

_____ If you do not present your updated insurance card or if you give us an incorrect insurance card and the claim is denied by the insurance, the patient will be responsible for any outstanding balance. **We will re-file the claim for you one time only.**

_____ Should your insurance deny a claim due to diagnosis or coding, our office will not change the initial diagnosis or coding just so your insurance will pay.

_____The parent or guardian who brings a child to his or her appointment and signs for consent of services takes full financial responsibility for the treatment the child receives. Our office will not split billing based on a divorce decree or other financial arrangements made outside of our office.

_____ I grant permission to contact me at any telephone number associated with my account. This will include wireless, home, and work or e-mail numbers that are provided. This also includes permission for different methods in which you may contact me i.e.: pre-recorded/artificial voice messages and/or use of automatic dialing devices and text messages.

_____ It is your responsibility to keep all of your information updated with our office such as addresses, phone numbers and responsible party information where statements should be sent.

_____There is a $30.00 returned check fee If your check is returned unpaid for any reason from your financial institution.

*** In the event that your account goes into default/collections, an additional $35.00 or 30% (whichever is greater) will be added to your balance. ***

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Signature of Patient or Responsible Party Date: