Broadway Family Dentistry

Financial Policy

We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. However, your deductible and any payment that is your responsibility will be collected at the time of service.

Our standard filling is the composite material, which carries a higher fee. Most insurance companies do not cover this restoration to the full extent. At your request we can substitute with Amalgam. However, we feel the quality is inferior. Please feel free to ask for the difference, if you wish to only receive the type of restoration your insurance carrier covers, let the doctor know.

We will be happy to request a pre-estimate of benefits from your insurance carrier if you request us to do so. Routine treatment is generally performed without submitting a request for pre-estimate of benefits.

Portions of the bill may not be covered by the insurance company and are to be paid by the patient. Sometimes there is a co-payment required by you as per your insurance agreement. Even if you have double coverage (this is possible if you and your spouse both have insurance) there may still a portion that will be your responsibility.

Patients without insurance are requested to pay for services as rendered unless prior arrangements have been made with the office manager.

Additional Terms / Cancelation Policy:

Appointments failed or canceled with less than **24** hours notice are subject to a **$25.00** cancellation charge for *each 1/2 hour of time*. Please note that balance originated from broken appointment fee must be paid in full prior to rescheduling the appointment at our practice. Checks returned by your bank are subject to a $35.00 processing charge. Accounts unpaid after past due warning are subject to a $25.00 billing charge.

We reserve the right to terminate the patient from the office if there are three broken/no show appointments.

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you the best care possible.

I have read and understand the financial policy of Broadway Family Dentistry.

Signature of patient: X_____ **Date:** X_____
(Parent or Guardian if minor)

Acknowledgement of Receipt of Privacy Practice Notice:

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: X _____ **Date**: X_____
(Parent or Guardian if minor)