

Financial Policy

Thank you for choosing Bronson Dental as your dental care provider. Our office maintains that every patient is entitled to the highest quality of dental care that can be provided. Your health and well-being are our primary concern. We appreciate the consideration you must give to the cost of your care. We welcome frank discussion concerning services and fees prior to treatment. Please understand that payment of your bill is considered apart of your treatment.

Your estimated portion for treatment is due at the time of service.

Appointments that are cancelled or otherwise broken without 24 hours notice are subject to a \$25.00 charge.

Insured Patients: Your insurance is a contract between you and your insurance company. All dental plans are not the same and do not cover the same services. It is your responsibility to know and comply with the terms of your insurance contract. In the event your dental plan determines a service to "not be covered" or payment is denied due to failure to company with the terms of the contract, you will be responsible for the complete charge. As a courtesy, we will file your claim on the day of service.

We are a preferred provider for and have agreed to the set reimbursement rates and conditions for:

-Cigna Health PPO	-GEHA Connection	-Tricare / United Con.	-SelectHealth
-Regence Blue Cross / Blue Shield	-Delta Dental	-Pehp	-DeCare
-Regence Valuecare	-Desert Mutual	-Met Life	-Aetna
-Dentemax			

For all other insurance plans our office is considered "out of net-work"

Non-insured Patients: If there is no insurance coverage, full payment is due at the time of service.

10% Savings option: If there is no insurance coverage or your insurance is one in which we are considered "out of net work" payment in full at the time of service by means of cash, check or credit card will accompany a 10% price reduction.

Payment Options: Our financial policy is designed to give you a number of payment options to choose from in order to make your dental care payment as easy as possible. For you convenience, you may choose any of the following methods of payment:

-Cash	-Visa or MasterCard
-Personal check or Debit	-Care Credit

WE DO NOT CARRY ACCOUNTS

I understand that the responsibility for payment of all dental services provided by Bronson Dental for myself and my dependents is mine. I understand I am responsible for my dental insurance co-payments, payment percentages, and procedures not covered. The information on my patient registration form is accurate.

Any balance after 30 days will have a FINANCE CHARGE of 1.5% per month of the unpaid balance added monthly. I agree and am fully aware that if for any reason it becomes necessary for Bronson Dental to take collection action on my account that I am fully responsible for all collection, legal and attorney fees. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

Print name of Patient / Responsible party _____

Signature _____ Date: _____

Informed Consent

I hereby authorize Bronson Dental to take necessary radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Dr. Bronson to make a diagnosis of my dental needs. I understand that the condition of any treatment necessary for my existing condition(s) will be fully explained to me and questions answered. I hereby authorize the Dr. Bronson and staff to perform those procedures, including the administration of local anesthesia and / or nitrous oxide, surgery as deemed necessary or advisable to my dental treatment. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with these treatment procedures in hopes of obtaining the potential desired results for my benefit. I understand that dentistry is not an exact science and no guarantees or promises with regard to my treatment can be offered.

Signature _____ Date: _____

Notice of Privacy Practices

I have reviewed and / or received a copy of the Notices of Privacy Practices for the office of Bronson Dental

Signature _____ Date: _____