BROOKSIDE DENTISTRY

Luke Foster, DDS

Financial Policy

We are dedicated to providing you with the best quality dental care possible to help you maintain optimum oral health for a lifetime. Our goal is to establish a long-term relationship with you and your family.

Dental Insurance
We may give you a treatment estimate based upon the best and only information available to us from your insurance company. Please remember that this is only an estimate of the cost of your care. Your estimated insurance benefit may differ from the actual cost due to a number of reasons specifically related to your plan, and could include but are not limited to:

- Exclusions and limitations of your insurance policy
- Waiting periods
- Use of alternative fee schedules by your insurance company
- Age restrictions
- Previous treatment already billed to your insurance company
- Specific treatment code restrictions

If you have any questions regarding your insurance benefit, we encourage you to contact your insurance company for further clarification. The cost of all dental care in this office is ultimately the responsibility of the patient or their legal guardian, regardless of insurance coverage. As a courtesy, we will assist you in the process of filing an estimation of benefits and submitting your dental insurance claims.

Responsibility of the Patient
Payment is due at the time of treatment, unless other arrangements are made. If you have dental insurance, co-pays and co-insurance amounts are due on the day your service is provided.

Missed Appointments/Cancellation Policy
Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best service to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in cancelling or missing your appointment. However, a charge may be assessed for multiple missed or short-notice cancelled appointments. Multiple failed appointments may result in being dismissed from the practice.

Collection Policy
A $35.00 late payment processing fee will be added to any balance over 90 days. In the event of a default on your account, we reserve the right to run a credit report for collection purposes.

I understand the above statements and agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my care.

Patient or Guardian Signature _____ Date _____