Broadmoor Dental Office Policy

Signature: I certify that I, _____ , (or my dependent) have dental insurance coverage and assign directly to Broadmoor Dental all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Patients without dental insurance coverage understand that they are responsible for 100% of the fees on or before the day of treatment.

Payments: Pre-payment is required for all prescribed/accepted dental treatment. Collecting in advance allows our office to reserve your time with the doctor. When you prepay for treatment you are agreeing to take care of your dental needs. Money that you prepay/pay for needed dental treatment will not be refunded. However, if you are refusing treatment and insist on a refund, you will be responsible for all charges incurred and may be assessed a cancellation fee. We have several payment methods we offer to our patients to assist them in taking care of their dental needs. If you use one of our finance companies and decide to change the terms of your account you will be responsible for all charges incurred. A $25.00 fee will be applied for any returned checks. A photo id is now required for all non-cash payments.

Billing Policy: As a courtesy, we will bill your insurance company for services rendered. Once payment is received from the insurance company, you will receive ONE patient statement for the balance due. It is expected that your payment will be made in 10 (ten) days. If your payment is not received, it will be considered past due and may be sent to collections. We reserve the right to impose a service charge of 2 % per month (18% per annum) on the unpaid balance on all accounts exceeding 30 days, unless previously written financial arrangements have been made. If an account is turned over to a collection agency and/or attorney for collection, the account holder will be responsible for all attorney and/or collection fees. Any balance that is ninety days (90) past due is subject to being sent for collection.

Unpaid Insurance Benefits: I understand that all dental services furnished, whether the patient has insurance or not, are charged directly to the patient and that he or she is personally responsible for payment of all dental services. If an insurance company has not paid a claim after sixty days (60) of it being submitted, the office will require that the patient pay the account in full. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. A photo id is now required with all insurance cards. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Treatment Estimates: The office routinely provides our patients with an estimate of cost for prescribed treatment. Since your insurance determines the benefits payable for services the office cannot be held responsible for 100% accuracy on any estimate for treatment.

Alternate Benefits: I understand that most insurance companies downgrade coverage on non-metal restorations and I agree to the adjusted fees for upgraded materials.

Condition of Treatment: As a condition of treatment by this office, financial arrangements must be made in advance, and financial responsibility (whether insurance remittance or patient portion) on the part of each patient is determined before treatment. All emergency dental services, or any dental service performed without financial arrangements, must be paid in full at the time services are performed.

Missed or Broken Appointments: Rescheduling an appointment may be done up to 48 hours prior to your scheduled appointment without expense. You will be assessed a $50.00 fee for the second missed appointment, and a $100.00 for the third missed appointment, after which the practice reserves the right to dismiss patients due to repeated rescheduling or missed appointments.

Broadmoor Dental reserves the right to update this Office Policy at any time without notification
My signature verifies that I have read, understood, and accepted the policies described above, and further grant you or your assignee permission to telephone me at home or at my work to discuss matters related to this form.

Patient Name_____

Signature of Patient or Guardian: _____ **Date:** _____

BROADMOOR DENTAL LAST NAME: _____FIRST NAME: _____ MI ____

DATE OF BIRTH _____/_____ /_____ MALE: [ ] FEMALE: [ ] SS#_____/_____/_____ TELEPHONE: _____

CELL PHONE: _____ WORK PHONE: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DL #_____ State issued_____ WEIGHT: _____lbs

PARENT/GUARDIAN: _____ PARENT OR GUARDIAN SS#_____/_____/_____

Are you in pain? _____ Where (example: upper right tooth)? _____ How long? _____
Has anything you have tried helped (example: pain pills)? _____ How long has it been since your last cleaning and examination? _____
Do you have any specific concerns about your teeth or dental care? _____
Do you or have you pre-medicated for dental visits, meaning have you been advised to take antibiotics prior to having dental care? _____ "Yes" or "No".
If yes, why? _____ Are you pregnant? If so enter due date: _____/_____/_____ Are You Nursing? Yes/No

Health History Of The Following:	Indicate Yes or No		Health History Of The Following:	Indicate Yes or No	
Anemia	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Hemophilia	Y	N
Artificial Heart valves	Y	N	Hepatitis	Y	N
Artificial Joints	Y	N	High Blood Pressure	Y	N
Asthma	Y	N	HIV/AIDS	Y	N
Back Problems	Y	N	Jaw pain	Y	N
Blood Disease	Y	N	Kidney Disease	Y	N
Cancer	Y	N	Mitral Valve Prolapse	Y	N
Chemical Dependency	Y	N	Neuroligic Problems	Y	N
Chemotherapy	Y	N	Pacemaker	Y	N
Circulatory Problems	Y	N	Psychiatric Care	Y	N
Cortisone Treatments	Y	N	Radiation Therapy	Y	N
Persistent Cough	Y	N	Rheumatic Fever	Y	N
Diabetes	Y	N	Scarlet fever	Y	N
Epilepsy	Y	N	Shortness of Breath	Y	N
Fainting	Y	N	Stroke	Y	N
Glaucoma	Y	N	Swollen Ankles	Y	N
Headaches	Y	N	Thyroid Problems	Y	N
Heart Murmur	Y	N	Tobacco Habit	Y	N
Heart Problems	Y	N	Tuberculosis	Y	N

List All Medications You Are Presently Taking:	What Is The Medication Being Taken For?	How Often Are You Taking The Medication?
DO YOU HAVE ALLERGIES TO MEDICATIONS OR ADVERSE REACTIONS TO ANY DENTAL/MEDICAL TREATMENTS?		
DESCRIBE ANY OTHER MEDICAL ISSUES OR SURGERIES:		
PLEASE PRESENT YOUR INSURANCE CARD & ANY CHANGES IN YOUR INSURANCE INFORMATION SO THAT WE MAY ASSIST YOU IN CLAIMS PROCESSING		
Primary Insurance	**Subscriber Name**	**Ins. Plan ID / Group No.**
Subscriber SSN	**Subscriber Date of Birth**	**Relation to patient**
Secondary Insurance	**Subscriber Name**	**Ins. Plan ID / Group No.**
Subscriber SSN	**Subscriber Date of Birth**	**Relation to patient**

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, or medications, or medical treatments I will inform the doctors at the next appointment without fail.

Printed Name:_____ Date:_____ Parent/Guardian of:_____

Signature:_____

PROVIDER SIGNATURE:_____

Broadmoor Dental

Oral Cancer Screening Consent Form

1930 S. Nevada ~ Colorado Springs ~ Colorado ~ 80905 ~ (719) 576.5566 ~ info@broadmoordental.com

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more that 25% of oral cancer victims have no such lifestyle risk factors.** Studies also suggest that human papillomavirus (HPV) plays a roll in more that 20% of oral cancers causes. Oral cancer risk by patient profile as follows:

Increased Risk:	Patients ages 18 – 39 Sexually active patients
High Risk:	Patients 40 and older Tobacco users: ages 18-39, any type within 10 years
Highest Risk:	Patients 40 and older w/ lifestyle risk factors (tobacco and/or alcohol use) Previous history of oral cancer

Broadmoor Dental has incorporated VELscope into our oral screening standard of care. VELscope, in conjunction with a standard oral cancer examination, significantly improves the ability to identify suspicious areas at their earliest stages. VELscope powered by Sapphire, along with the doctor's visual examination, is similar to proven early detection procedures for other cancers such as mamography, and gives the best chance to find any abnormalities at the earliest possible stage. As with all cancer early detection can minimize or eliminate potentially disfiguring effects and possibly save your life.

The VELscope powered by Sapphire examination will be offered to you annually. This enhanced examination is recognized by the American Dental Association, however it is not recognized by most insurance companies.

The fee for this enhanced examination is $25.00 and is due on the date of service.

☐ Yes. Along with my standard oral cancer screening, I would prefer to have the VELscope enhanced examina tion at this time.

☐ No. I would prefer not to have the VELscope enhanced examination at this time and prefer the standard oral cancer screening alone.

Print Name_____Signature_____ Date_____

Broadmoor Dental
Patient Financial Policy Notice

Thank you for selecting Broadmoor Dental for your dental care services. We are committed to providing the highest quality of care. As a courtesy to you, if applicable, we will bill your insurance company for any services rendered.

You have been/will be given a Treatment Plan Estimate detailing your estimated patient co-pays for any/all prescribed dental work. Insurance remittance estimates are provided as a courtesy and are based on current information collected from insurance carriers. While we would like to advise you of your exact financial obligation before your date(s) of service, the scale of different insurance plan designs make it extremely difficult. Your co-payment or patient portion may vary based on actual payments made by your insurance provider.

Claims for your dental care are submitted on the day treatment is completed. In the event your insurance carrier remits less than the estimated amount of the claim, for any reason inclusive of denied claims, the patient/responsible party, is financially responsible to pay the unpaid balance.

Bills for any amount due will be sent to you upon receipt of remittance or explanantion of benefits by your insurance company. Payment is due within 10 business days from the date the bill is mailed. If payment is not received by the noted due date, it will be considered PAST DUE and may be sent to collections. Any questions or arrangements pertaining to your bill must be addressed within this 10 day period to keep this account in our office.

Financial Responsibility Agreement

Broadmoor Dental is committed to providing the highest quality care services to our patients. In return, I agree to be financially responsible for payment of Broadmoor Dental's services. Initial:_____

I agree to give Broadmoor Dental complete and accurate insurance information for any primary/seccondary insurance coverages. I understand that failure to supply complete and accurate information may result in denial of my claim or delay of insurance remittance. I understand that Broadmoor Dental has the right to close any unpaid claim that is older than 60 days from the date of service. I agree to pay any balance remaining on my account after my insurance claim(s) are processed.

Initial:_____

I understand my financial responsibilities as they may relate to my dental insurance plan, and understand that any insurance portion(s) not paid by my insurance company(ies) are my financial responsibility. In the event of self-pay patients, non-insurance based treatment, I understand that I will be given a detailed treatment and fee estimate prior to any dental work being performed. I understand that I will be 100% financially responsible for the cost of such treatment.

Initial:_____

I acknowledge that dentistry is not an exact science and changes in treatment may become necessary during the course of my care. I understand that I will be kept informed of any necessary changes and acknowledge that I will be financially responsible for any such changes.

Initial:_____

I understand that any invoice or receipt issued by Broadmoor Dental is a non-binding estimate only, and additional charges may apply depending upon actual amounts remitted by my insurance company for services rendered. I agree to pay any balance remaining on my account within 10 days upon receipt of a statement requesting payment.

Initial:_____

Please acknowledge your understanding of this notice and your willingness to comply with the above.

_____ _____

Patient/Family Name Financially Responsible Party Date