Boyle DENTISTRY

Consent for Services

I understand it is my right and duty to ask any questions and receive explanation about my condition or treatment, including any alternate treatment. Unless otherwise acknowledged, I consent to treatment and understand that no guarantee can be made concerning the results of procedures performed.
As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Therefore, fees for recommended treatment will be reviewed and payment method determined prior to scheduling for said treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in obtaining reimbursement from insurance companies and will credit any such reimbursements to the patient's account. Any unpaid insurance claims will become the patient's responsibility after 60 days from the date services were rendered. I give authorization to Boyle Dentistry to keep my updated bank card/account information on file and consent to use this information for payment purposes on balances aging over 60 days upon proper notification.
A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. A fee will be charged for any returned payments and may be turned over to a third party for collection efforts.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. I further agree to pay all costs and collection fees in the amount of 33 1/3% of the total indebtedness then due if collection procedures or suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Payment Options

We do not want finances to be an obstacle in obtaining your dental health needs, so we have setup many different payment options for treatment. All Insurance claims are handled by the office as a convenience to you. We do ask for insurance co-payments and deductibles at the time of service. We will review all estimates with you when presenting treatment recommendations.

Payment options include:

- **Cash / Check payment**- We offer a 5% professional courtesy for pre payment of treatment plans exceeding $300.
- Bankcards (MasterCard, Visa, American Express, and Discover)
- Appointments for restorative needs will require a portion of the estimated patient's co-payment at time of scheduling.
- Extended payment plan options. (Requires credit application)
  $300.00 or more – 3 Months no interest
  $600.00 or more – 6 Months no interest
  $1,000.00 or more – 1 Year no interest

Broken Appointments

We want to minimize lost time for your treatment and for others awaiting appointments. We ask for the courtesy of no less than 2 business days notice if you are not able to keep your scheduled appointment
A missed appointment charge may apply if less than 1 business days notice is given.
The rates are as follows:

- Less than 1 hour reserved time: $50.00
- 1 hour or greater of reserved time: $90.00

I have read the above conditions of treatment and payment and agree to their content.

* _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent, or guardian