Thank you for choosing **Dr. Ronald O’Boyle’s Office** for your dental care. Our mission is to deliver the best and most comprehensive dental care possible. We strive to provide optimal care that is timely, easy, and manageable for our patients.

The following is a statement of our Office Policy, which we require that you read, agree to and sign prior to any treatment.

**APPOINTMENT SCHEDULING:**

Your scheduled appointment time has been reserved specifically for you. We request a 24-hour notice if you need to cancel your appointment. A fee of **$35** may apply for cancelled or failed appointments with less than 24-hour notice. This notice allows the dental team time to offer your reserved time to another patient.

We are aware that unforeseen events sometimes require missing an appointment, and we appreciate your cooperation in this matter.

**CELL PHONES:**

To better serve you we ask that patient cell phone usage be restricted in treatment areas.

**FINANCIAL OPTIONS:**

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit.

A fee of **$50** will be charged for any returned check, in addition to any fees charged by the banking institution.

**DENTAL INSURANCE AND ACCOUNT BILLING:**

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for services. Once final benefit payment is received, we will send you a billing statement for any balance that is due.

Any account balances that remain unpaid for more than **30 DAYS** from the statement date shall accrue at the rate of **18%** per year (1.5% per month), and may be referred to a collection agency or attorney after **180 DAYS.** In the event that this occurs, you will be liable for collection costs totalling a minimum of **$100.** Further, in the event any unpaid account balance is referred to an attorney, you will also be responsible for all costs and reasonable attorney’s fees incurred in connection therewith.

**Initials: \_\_\_\_\_\_\_\_\_\_\_**

*I authorize Dr. Ronald O’Boyle and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, or by any other form of electronic communication regarding payment due for services rendered.*

*I understand that my dental insurance benefits may not cover the cost of some or all of my treatment. I understand that I will be responsible to pay for all non-covered items and services not covered by insurance. I consent to the dentist’s use and disclosure of my health information, to my insurance company and its agent I understand and acknowledge that I am fully and completely responsible for the payment of the costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company and me, my spouse, and/or my employer. The dentist is not a party to this contract and the services, treatments, and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company, and I acknowledge that I will remain liable for any and all of the amounts not paid by the insurance company or managed care company for any reason, including but not limited to the insurance company declining coverage after initially approving it, or if the insurance company fails for any reason to reimburse the dentist within* ***30 DAYS*** *after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance company and any changes thereto.*

*I voluntarily and knowingly request and consent to the services, treatments, and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but is not limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services and treatments and/or procedures and utilize all such diagnostic methods. Further I acknowledge and understand the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods. I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, and/or diagnostic methods that have been recommended.*

**I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE FOREGOING TERMS. ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE FOREGOING TERMS AND AGREE TO BE BOUND BY THEM.**

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**Patient or Guardian Signature Date/Time Relationship to Patient**

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**Witness Signature Date/Time**