Darren Boles, D.D.S., P.L.L.C.

Purpose: This form is used to obtain acknowledgement of receipt of the policies of Dental Expressions, Darren Boles, D.D.S., P.L.L.C. as listed below and to document our good faith effort to obtain that acknowledgement.

After reading our policies, please initial next to each area and then sign the bottom of this page. Your signature will acknowledge being informed of our policies.

______ (initials) I have read a copy of this office's **Notice of Privacy Practices**.

______ (initials) I have read the information provided to me about **Dental Restoration Materials Facts** and understand the risks and benefits.

______ (initials) I have read the **Local Anesthesia Informed Consent** and understand the risks and benefits.

______ (initials) I grant permission to the office of Dr. Darren Boles for the use of the photograph(s) or electronic media images to be used for education and/or marketing.

______ (initials) I understand that payment in full is expected at the time of service. For insurance, I agree to pay the uninsured portion of my visit at the time of service and will pay any balance that my insurance does not cover. Failure to pay for treatment within 60 days will result in an 18% annual (1.5% per month) finance charge. After 90 days outstanding, my account may be turned over to a collection agency or a lawyer and all future scheduled appointments will be cancelled. Appointments can be rescheduled once balance is paid in full. I understand I will be responsible for any costs associated with the collection of my outstanding balance, including (but not limited to) court costs, lawyer fees, and/or collection agency fees.

______ (initials) I understand that my signature below also authorizes Dr. Darren Boles, D.D.S., P.L L.C to release requested dental information to my insurance company and/or any health care professionals involved in my care.

______ (initials) I agree to give a 48 business hour notice if I must cancel an appointment. If I do not give proper notice I understand a fee will be accrued for the missed appointment.

______ (initials) *New Hampshire Medicaid Patients:* I understand that Dental Expressions requires me and/or my family to give 48 hours notice for scheduled dental appointments. If I fail to give notice 2 times I will be terminated as a patient.

Please print your name and sign below. Your signature acknowledges being informed of our policies and for insurance purposes if applicable.

_________________________________ (Name Printed) ______________________________ (Signature) _____________ (Date)

*Please tell us how you heard about our practice*____

____.

Financial Policies / Missed Appointments

- **Payments:** All payments are due at the time services are rendered. If you have insurance, this includes your co-payments and deductions as stated in your policy. In the event that insurance does not cover what was estimated at the time services are rendered, you are responsible for the remaining amount.

- **Delinquent Accounts:** Accounts that become delinquent will be treated as follows:
  - 60 Days: 18% APR (1.5% Monthly) will be charged for any outstanding balance.
  - 90 Days: Your account will be considered for termination and collection agency procedures.

- **Missed Appointments:** an appointment is considered "Missed" when we are not given 48 hours notice.
  - The first missed appointment: patient will receive a phone call to reschedule and will receive a copy of this policy in the mail. They will be allowed to reschedule.

  - The second missed appointment: If a patient has another missed appointment within the next six (6) months, or two (2) consecutive missed appointments, they will be charged accordingly
    - Hygiene Appointments: $50.00
    - Dentist/Assistant Appointments: $40.00 per unit (15 minutes) scheduled. If the appointment was for an hour and a half the fee will be assessed at $240.00. An additional $50.00 charge will be added on top of the regular fee for any appointment that was scheduled for 2 hours or more. An appointment scheduled for 2 hours would be $320.00 plus $50.00, totaling $370.00.

    The patient may then only call the day on which they would like an appointment but may or may not be given an appointment that day based on need and appointment availability.

  - The Third missed appointment: If a patient has another missed appointment within the next six (6) months, or three (3) consecutive missed appointments, they will be dismissed. We then allow emergency dental care for the next thirty (30) days and patients are encouraged to seek dental care elsewhere.