BOS DENTAL

PATIENT RESPONSIBILITY AGREEMENT/PAYMENT OPTIONS

We will be happy to process your Insurance Claim Forms. While this is a courtesy we extend to our patients, ALL charges are the responsibility of the patient. We will do our best to ESTIMATE your portion of payment at the time of service; however, it is the patient's responsibility to verify eligibility of their plan. The patient must pay any estimated portion AT THE TIME OF SERVICE.

Insurance companies use the term "Usual and Customary" when setting fee limitations on services. The term suggests, but does not necessarily reflect the average fees charged by the dentist in the community. Please be aware that some insurance companies will pay a claim based on their "Usual and Customary" fees, not our actual charges. Therefore, the difference between what we bill and what they pay is the patient's responsibility.

Any insurance disputes that may occur are between the patient and their insurance providers.

I authorize my insurance benefits to be paid directly to Dr. Bernard Bos, D.D.S and I am financially responsible for non covered services. I also authorize the release of any information required to process any claim generated from this office.

Payment for today's visit and future visits are due at time of treatment. We are sensitive to the fact that some patients may not be able to pay cash for their treatment; therefore, we can offer an alternative payment program for your convenience.

Collection action will be taken on all accounts that are past due. If this agreement is placed with a collection agency or an attorney for collection, the non prevailing party agrees to pay all attorney fees.

Returned checks will be assessed a $25.00 charge. We will require you to pay this balance in full within 2 business days. We do not resubmit them.

There will be a $50 charge for a missed or cancelled appointment without a 48 hour business notice. Multiple broken appointments may lead to dismissal of patient.

If a patient wants a copy of their dental records, there *may* be a $30 fee assessed. Please give us a 48 hour business notice to duplicate any dental requests. We will also need a "Release of Record" form filled out prior to sending or emailing any records.

Thank you for your understanding.

Patients Name (Please PRINT):_____Date:_____

Patients Signature/Guardian:_____