Assignment of Insurance Benefits & Payment Policy

By signing the Consent for Services, you authorize direct payment to I. Bohay, M.S., D.D.S. and assume responsibility for all non-covered services or provider charges that may exceed insurance payment.

I understand that I am to pay at the time services are rendered for all charges not billable to my insurance company. I understand that it is my responsibility to pay I. Bohay, M.S., D.D.S. promptly for all services rendered regardless of any disagreement between the insurance company and myself. I understand that if my insurance company fails to pay within sixty (60) days, I. Bohay, M.S., D.D.S. will assume it to be a non-covered service and will expect me to pay.

Our payment plans are as follows:

- **Payment or copayment is required the day services are rendered.**
- **If you are unprepared to pay your balance, a $3 service fee will be charged to your account. The balance is to be paid within 2 weeks from the day of service.**
- **Returned checks are subject to a $30 NSF fee and may be subject to an additional collection fee.**
- **Balances over 30 days may be subject to additional collection fees.**
- **All accounts not paid within 90 days will automatically be sent to a collection agency.**

Accounts may be paid by Cash, Check, Visa, Mastercard, Carecredit or prior financial arrangements with the office.

Patient Participation

Patient Noncompliance

I understand that I am expected to be an active participant in my health care. Dr. Ihor Bohay has the right to terminate me from the practice if I repetitively demonstrate non-compliant, inadvisable health practices, or if I am abusive in my conduct toward Dr. Ihor Bohay or his staff.

Delinquent Account Policy

I understand that if my account becomes seriously delinquent, it may be referred to the Credit Bureau and Collections Service as provided for by the laws of this state. This may affect my credit rating for many years to come. Should this occur, I will receive a letter at home stating our policy clearly, and will be given alternatives for finding medical care elsewhere.

Missed Appointments

I understand that Dr. Ihor Bohay schedules by appointment only. I understand that if I am unable to keep an appointment I should call and cancel that appointment as soon as possible. (Ideally, we request 48 hour notice.) I also understand that if I repeatedly do not cancel or do not show up for my appointments, I will be assessed a No-Show fee of $50. *Letting us know that you cannot keep your appointment allows us to offer that time slot to another patient.*

Consent for Services

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, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services not paid by insurance are charged directly to the patient and that he or she is personally responsible. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In order to process a claim for benefits, I authorize I. Bohay, M.S., D.D.S. to release to my insurance company, any information requested regarding my dental history, symptoms, treatment, and radiographs. A photocopy of this signed release shall be considered as effective and valid as the original.

Patient Acknowledgement/Consent

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

I have had full opportunity to read and consider the contents of this form. I understand that by signing below, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

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 and I further agree to pay all costs and reasonable attorney fees if suit is to be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at work to discuss matters related to this form.

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

_____ _____

Signature of patient, parent, or guardian Date

Thank you for your cooperation and consideration with regard to these matters.

Dr. Ihor Bohay and Staff