Office/Cancellation Policies

Cancellation Notice:

We require 24-hour notice for all appointments that need to be cancelled. If we do not receive the required 24-hour notice, there will be a fee charged to your account. The fees are as follows:

- An hour or less appointment: $25
- A two hour or less: $50
- An appointment over 2 hours: $100

This is an express policy of our practice that is not applicable to any dental insurance or rules or regulations. Missed appointments effectively prohibit us from providing availability and care to patients with true dental needs. The 24-hour notice allows us time to schedule another patient that would benefit from treatment and fosters a mutual consideration and respect for our time and yours.

Telephone Consumer Protection Act (TCPA):

I agree that the office of Dana R. Boehm DDS, PC or any other collection or servicing agency retained by our office (together referred to hereafter as "collectors") to collect money that I owe to the office may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge, and agree that the collectors may contact me by automatic dialing devices and through prerecorded messages, artificial voice messages, or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Assignment of Benefits:

I certify that the information I have given to Dana R. Boehm DDS is true and correct to the best of my knowledge. I promise to pay to Dana R. Boehm DDS all charges and expenses for services provided to me by Dana R. Boehm DDS in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance. I understand that possession of dental insurance does not relieve me of financial responsibility to Dana R. Boehm DDS. I will personally be responsible for all charges for services that are not covered by my insurance carrier.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

If patient is a minor (less than 18 years of age) or emancipation:

Guardian: _____ Relationship: _____

Signature: _____ Date: _____