Jerry J. Boyd, D.D.S.

6620 Colleyville Blvd. • Suite 200 • Colleyville, TX 76034

Preferred Patient Organization (PPO) Contract Agreement

Enrolling in our PPO provides the following benefits:

• Two preventive appointments per year. Preventive appointments include a routine cleaning (in absence of periodontal disease*), complete oral examination, and annual x-rays.

• Every three years you will receive panoramic full mouth x-rays at no additional cost.

• Two emergency exams per year. This includes x-rays, if necessary.

• 20% off restorative dental services including fillings, one-visit Cerec crowns, root canal therapy, bonding, periodontal therapy, and more.

• 15% off restorative services that require dental lab services such as bridges, porcelain veneers, dentures, partials, and lab fabricated crowns.

*Patients on a periodontal disease maintenance routine who require more than two cleaning appointments per year will receive 20% off the normal fee for any additional cleanings.

Terms:

Annual fee: $280 for adults; $230 for children (under age 14)

• **1st year options**: Paid in full- $280(adults) $230(children) at first appointment/contract signing.
Installments: $140(adults) $115(children) paid at first preventive appointment/contract signing. $140(adults) $115(children) in 6 months.

• **2nd year options**: Paid in full- $280(adults) $230(children) at first appointment/ contract signing.
Installments: $140(adults) $115(children) paid at first preventive appointment.
2nd Installment: $140(adults) $115(children) due in 6 months.
Monthly Direct Debit of $28(adults) $24(children)

Patients are eligible to join the PPO at any time. Once enrolled, date of enrollment will be considered the contract date. Payments must be made by due date (contract date) to continue participation. Patients who do not renew on or before their contract date will be ineligible to participate in the PPO until the next year's contract date.

Dr. Jerry J. Boyd reserves the right to review and update fees on an annual basis.

Date_____ Patient Signature_____

Date_____ Witness Signature_____