Patient Name:___________________________________Date:_________________

Johnson Dentistry is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- ALL PATIENTS MUST COMPLETE OUR “PATIENT INFORMATION FORM” BEFORE SEEING THE DENTAL PROFESSIONAL
- FULL PAYMENT IS DUE AT THE TIME OF SERVICE
- WE ACCEPT CASH, CHECKS, VISA, MC, DISCOVER, AND CARE CREDIT
- JOHNSON DENTISTRY PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENTS PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT TIME OF SERVICE.

(INITIAL)_____________

Adult Patients

Adult patients are responsible for full payment at time of service

(INITIAL)_____________

Minors Accompanied by an Adult

The adult accompanying a minor, his/her parent/guardians are responsible for full payment at time of service.

(INITIAL)_____________

Insurance

We are happy to work with your insurance carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, your estimated copay is due on each date of service.

(INITIAL)_______________

Delinquent Payments:

Should an account become over 90 days delinquent, I understand, that it will be turned over to a collection agency for recovery of past due charges. The patient, parent/and or guardian will be responsible for any collection, court and attorney fees.

(INITIAL)_____________

Missed Appointments:

A fee of $40 is charged for appointments canceled with less than **24 HOUR NOTICE** or **FAILED** appointment.

(INITIAL)______________

THANK YOU FOR UNDERSTANDING AND ACCEPTING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS

Responsible Party Signature______________________________Date_________________