FINANCIAL POLICY

Dr. Jennifer Johnson and her staff are committed to providing your child with the best possible care. We believe we have a responsibility to use our best professional care, skill and judgment in planning for your child's dental treatment. Our office operates on a fee-for-service basis. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. The coverage provided by insurance companies varies from company to company. It is impossible for our office to know how much each company pays for each procedure and what they do not cover, therefore, it is important for you to become familiar with your insurance coverage. Please bring your insurance card(s) with you to expedite the filing of your claim.

The fact that your insurance company chooses not to cover a certain dental procedure does not mean that the procedure is not important for your child. Generally, a way in which your employer seeks to minimize the cost of insurance is by eliminating coverage of certain dental procedures, even though they are necessary in providing the best dental care for your child.

As dental care providers, our relationship is with you, not your insurance company. We are happy to assist you in filing insurance, however, the responsibility of payment for our services is yours. Payment for services is due at the time services are rendered. If you are covered by dental insurance, you will be expected to pay your estimated portion on the date of service.

For your convenience, we accept cash, checks, MasterCard, Visa, Discover and American Express.

By signing below, you have indicated that you agree that all fees should be properly explained to you and you agree to fulfill your financial commitment to our office promptly and completely. No business or practice can fulfill its mission to its patients when a bond of trust is violated by failure to pay for services.

Should it be necessary to take action to collect any amount owing under this agreement, you agree to assume the cost incurred to collect including , but not limited to, collection agency fees, attorney fees, court costs, and interest accruing thereon at the rate of 1 ½% per month.

Date: _________________________ Patient: _____________________________

Signed: ________________________ Relationship __________________________