INSURANCE AND PAYMENT POLICIES

FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT. For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator prior to treatment.

- **For patients with Dental Insurance:**
  Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
  - We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
  - Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  - All insurance benefits are assigned to Smile 4 Life Dental or Dr. Johnson, unless services are paid in full the day of treatment.
- Please note, for your convenience, we accept VISA, MasterCard, Discover, American Express, and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. If you must change or miss an appointment, we require a 24-hour notice. Cancellations, last minute rescheduling, or failure to show will result in a broken appointment charge of $50, or no reappointment. If more than one family member is scheduled and fails to make their appointment, a $50 cancellation fee will be assessed for the first individual and $25 for each family member thereafter. The policy is strictly enforced due to our high volume of patients.
- Our office will provide confirmation calls, emails, texts, and/or reminder postcards.
- The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- All collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account.
- Treatment appointments made that exceed $500.00 will require 10% down to hold the appointed time.

CONSENT

I have read and understand all the above information. If I ever have any change in my health or change in my medication, I will inform the Doctor or Dental Hygienist at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Signature (Patient, Parent, Guardian): ______________________________________ Date: _____________