

**M. Kenneth Johnson, D.M.D., P.A.**

Our business staff wants to assist you in the financial management of our relationship. Please be advised of our billing and collection policy. If you have any questions please speak with our business staff. Be assured that we will be ethical and fair concerning any billing or collection concern you may have.

**INSURANCE:**

The patient is responsible for full balance at the time of service.  
As a courtesy our billing department will file your insurance for services rendered.  
The patient is responsible for presenting all **current** available insurance cards at the time of service.  
The patient is responsible for all deductible, co-insurance at the time of service.  
The patient is responsible for knowing their policy coverage, deductible, coinsurance, etc.  
The patient is responsible for insurance follow-up with their plan regarding student status forms, annual employer claims forms, and terminated insurance plans.

**SELF-PAY PATIENTS:**

Patients with no insurance coverage will be considered self-pay.  
Self-pay patient will sign this form indicating that they have **NO** dental insurance coverage.  
Self-pay patients are responsible for full balance at time of service.

**COLLECTIONS:**

Collection notices begin if the balance has not been paid within 90 days.  
All unpaid balances will incur a 30% collection fee and be sent to an outside collection agency after all practice efforts have been exhausted. This will result in a negative credit rating.

\_\_\_\_\_ I **DO NOT** have dental insurance coverage.

\_\_\_\_\_ I have dental insurance coverage with \_\_\_\_\_ (company name).

Patient Signature

Date

Office Staff Signature

Date

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***POLICY FOR BROKEN APPOINTMENTS: A \$75.00 CHARGE WILL BE INCURRED FOR APPOINTMENT CHANGES WITHOUT 48 HR. NOTICE.***