David A. Johnson, DDS
FAMILY AND COSMETIC DENTISTRY

Office Policy

Welcome to our office! We are glad you are here! Please take a moment to review our office policies. We are happy to answer any questions you may have.

Appointments

We will schedule your next visit with us before you leave the office, making sure you understand what to expect at your next visit. If you have any questions feel free to question us at that the time or call us at your convenience.

We make every effort to run on time. This is a joint effort by the entire office and can best be accomplished with your help as well. Please try to arrive for your appointment on time. We know your time is important, and barring an unexpected emergency, you will find we are on time and looking forward to seeing you.

If there is a need for you to cancel your appointment we require at least 24hr notice. A $75 fee will be charged for a failed appointment.

Payment Options

Patients Without Insurance

Patients may pay in full for their treatment upon it's commencement. Payment in full with cash, check or credit card at the start of treatment earns a 5% savings on the fee for your treatment.

Patients may pay 1/2 of the fee on the day treatment begins and take care of the remaining 1/2 on the day treatment is completed.

Patients With Insurance

We recommend obtaining a predetermination of your dental benefits from your insurance company before commencing treatment. Some services we provide are deemed cosmetic by insurance carriers and therefore may not be covered by your policy.

Patients may choose to pay the total amount at the beginning of treatment, just as if they did not have insurance. This will allow you to take advantage of the 5% savings on the fee for your treatment. We will assist you in recovering any insurance benefits.

Or, you can pay your estimated portion, based on the predetermination of your benefits, at the time of treatment. After your insurance has been billed and payment received any balance will then be due.

I have read and agree to be bound to all the above office policies. I understand that I am responsible for payment of all services rendered by Dr. Johnson, Dr. Silvers, or the staff at the time of treatment, unless other arrangements have been made. I am responsible for any co-payment and deductibles my insurance doesn't cover. I agree to pay in full for any procedure not covered by my insurance or for any procedure my insurance reduces coverage for due to their alternative benefit policies. I authorize my insurance benefit payment to go directly to Dr. Johnson or Dr. Silvers. I authorize Dr. Johnson and Dr. Silvers to release all examination and treatment records to my insurance company.

The above information is true to the best of my knowledge. I have read and agree to be bound to all the above office policies.

_____	_____
Date	Signature of patient or legally authorized representative
_____	_____
Relationship to patient	Printed name of patient and representative (if different)