321 N. Breiel Blvd. 513-424-3971
Middletown, OH 45042

2309 Woodman Dr. 937-252-9070
Kettering, OH 45420

9684 Cincinnati Columbus Rd. 513-777-5369
West Chester, OH 45241

Garland & Johnson Dental

PATIENT PAYMENT POLICY

In order to keep dental cost down, we request that patients pay their copay as services are rendered unless other arrangements have been made with the business office.

INSURANCE

Our practice is committed to you by providing you with the highest quality of dental care available. Our fees are determined by the actual cost of treatment not the insurance companies arbitrary determination of USUAL AND CUSTOMARY RATES.

As a courtesy to you, we submit all insurance claims and obtain the dental benefits you and your family are eligible to receive through your insurance carrier. However, this is only an estimation of coverage. Your insurance policy is a contract between you and your insurance company, we are not a party to that contract, therefore, the balance of your account is your responsibility regardless of what your insurance company reimburses for services rendered.

CO-PAYS

- We require your DEDUCTIBLE and ESTIMATED CO-PAY paid at the TIME OF SERVICE.
- We cannot bill an insurance company for any claim unless all information is received from the patient.
- We request insurance information and patient history be updated annually. If your insurance company has not paid it's estimated portion within sixty (60) days the amount outstanding will be transferred to your account and will become your responsibility.

IF SUFFICIENT INSURANCE INFORMATION IS NOT RECEIVED, THE ENTIRE FEE FOR SERVICES RENDERED WILL BE DUE AT THE TIME OF THE APPOINTMENT.

BROKEN APPOINTMENTS

We understand that occasionally situations may arise to warrant a broken appointment. However, this can leave a serious void in our schedule. We request 48 hours notice so that this time can be used for another patient in need of treatment. Therefore, WE RESERVE THE RIGHT TO CHARGE FOR AN APPOINTMENT CANCELLED OR BROKEN WITHOUT A 48 HOUR ADVANCED NOTICE. THERE WILL BE A $40.00 CANCELLED OR BROKEN APPOINTMENT FEE FOR MISSED APPOINTMENTS.

Our goal is to make your dental appointments as comfortable and as pleasant as possible, if you have any questions, suggestions or concerns, please feel free to discuss them with any of our office staff.

**I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account. In the event that the account would be sent to a collection agency or attorney due to non-payment on the account, I am responsible for all collection fees or charges.

I understand by signing this form, the insurance company will release checks to the office. I also understand that the office submits claims electronically.

Signature Patient/Guardian_____Date_____