Garland & Johnson Dental

321 N. Breiel Blvd., **Middletown**, OH 45042
513.424.3971
2309 Woodman Dr., **Kettering**, OH 45420
937.252.9070
9684 Cincinnati Columbus Rd., **West Chester**, OH 45241
513.777.5369

Patient Payment Policy

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care and convenient financial arrangements.

Please read and initial the following:

INSURANCE: _____
Our office is committed to helping our patients maximize their dental benefits. We are available to answer most of your questions about your coverage; however, your policy is a contract between you and your dental insurance company. We are only able to provide you with estimated co-pay which is due at the time of service. As a service to our patients, we will bill the insurance company and allow them 45 days to render payment. After 60 days it becomes your responsibility to pay the balance in full. Insurance policies vary; therefore we cannot guarantee coverage or the amount to be covered due to the complexities of insurance contracts. Please understand that some insurance policies cover posterior white (tooth colored) fillings and/or crowns at a reduced (silver, amalgam, etc.) rate which could result in a different co-pay. We do not offer treatment based strictly on your insurance, but rather what we feel is best for our patients' overall health and care.

PAYMENT OPTIONS: _____
We accept the following methods of payment: cash, check, MasterCard, Visa, Discover and American Express. We also offer payment plans through CareCredit and Lending Club. Payment in full is due at the time of service unless prior arrangements have been made.

SERVICE CHARGES: _____
The policy of this office is to charge $15.00 a month late fee for all accounts over 90 days past due. We charge $40.00 for insufficient fund checks. Additional fees may apply for excessive balances.

MISSED APPOINTMENTS: _____
Please remember that once an appointment has been made, it is specific time reserved for you. We reserve the right to charge $50.00 for missed hygiene appointments and/or $75.00 for missed dental restorative appointment.

TREATMENT TO BE DONE: _____
Our primary mission is to deliver the best and most comprehensive dental care available. Please understand that during treatment it may be necessary to change and/or add procedures because of the conditions found during treatment that were not evident during the initial examination. A full treatment plan will be given to you upon comprehensive exam completion. If you choose not to do the treatment that has been suggested to you, you may be asked to sign a refusal statement. Please note that if treatment is not completed within a reasonable time, treatment may change as well.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: _____
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. A copy of this HIPPA Compliance Form is available upon request.

Signature Patient/Guardian: _____ Date: _____