Stacy D. Johnson, DDS, MS
Financial Menu

Thank you for choosing our practice for your family dental care. Our goal for our patients is to experience a pleasant dental environment, while providing the finest care available. We strive to keep our patients families well informed of their dental needs, treatment alternatives, as well as financial options to make your total dental experience as comfortable as possible. This menu is designed to help you better understand our financial policies.

PAYMENT

Payment is expected the day dental services are provided. For your convenience Master Card, Visa, Discover, American Express, debit cards, checks and cash are accepted. As dental needs are diagnosed, a treatment plan will be provided showing these needs, estimated fees and payment due to begin treatment. If a financial concern is anticipated, in which payment in full was arranged cannot be remitted, please inform our office immediately. We offer approved extended payment plans through an outside source.

DENTAL INSURANCE

If you have the benefit of dental insurance, we accept most Primary Insurance Plans that do not require a specific provider. Please bring your identification card, signed insurance form and benefit booklet to your first visit. Dental insurance is not intended to be a "pay-all" service, but to help reduce "out-of-pocket" expenses. We will file Primary Dental Insurance Claims. Please be prepared to pay deductible and estimate co-payment in full as treatment is initiated. Please note, we do not accept assignment of benefits for Secondary Insurance. Therefore, after Primary Insurance responds any remaining balance is due in full. As a courtesy, we will prepare a Secondary Insurance Claim form, submit the claim and request the carrier reimburse the subscriber directly.

INSURANCE PAYMENT

As a courtesy, we will file your Primary Insurance Claims and are willing to wait up to 60 days from date of service for the insurance to respond. We will contact your carrier and determine if there is a delay and strive to resolve the delay; a statement will be forwarded at that time and payment is due in full by responsible party. We'll instruct the dental carrier to reimburse the Insured Party directly. As a healthcare provider, our relationship is with you, not your insurance company. Our primary concern is for the well-being of your family and structure our care accordingly. Insurance companies determine benefit packages and payment rates (usual and customary fees –UCR) by the type of plan that is purchased by the employer/insured party-not the level of care the patient needs. All charges are your responsibility from the date services are rendered, regardless of insurance benefits, arbitrary determination of UCR, or lack thereof.

APPOINTMENTS

We see patients on a "by appointment" basis and ask you to call in advance to reserve time for your family. If you experience a scheduling conflict with a reserved appointment, please provide at least 24 hour advance notice for scheduling changes. In instances where appointments are cancelled or failed with 24 hours notice or less, a fee of $50 per hour may be charged to your account.

RETURNED CHECK FEE

A fee of $20.00 of 5% of the balance, whichever is greater will be charged for any returned check. After two returned checks are received, the account will be placed on a "cash only" basis. The outstanding balance and returned check fee must be paid immediately upon notification form our practice and prior to the next scheduled appointment.

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable for the patient named, including but not restricted to drugs, medicine, performance or operations and conduct of laboratory, x-ray, or other studies that may be sued by the attending Doctor, staff or qualified designate. I authorize Stacy D. Johnson, DDS, MS to release any information to a third party and/or health practitioners. I authorize and request my insurance company to pay Stacy D. Johnson, DDS, MS directly, otherwise payable to me. I understand my insurance carrier may pay less than the total bill for services and unconditionally agree to be responsible for and to pay all charges incurred on my behalf or my dependents. In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge or if no such arrangements are made, then payment shall be made in full within fifteen (15) days of discharge. I/We understand that in the event of default in payment, reasonable collection agency fees, reasonable attorney fees and incidental expenses shall be added to the amount due on the account, plus any applicable court costs. I further understand a 15% finance charge per month (18% annually) will be added to my account for any balance over 60 days, regardless of pending insurance claims. I agree to pay Stacy D. Johnson, DDS, MS a minimum fee of $50 for the first hour and $25 for every half hour proceeding for any appointment I schedule and fail to arrive or cancel with less than 24 hours advance notice. The information I have given today is correct to the best of my knowledge. I also understand this information will be held in confidence and it is my responsibility to inform Stacy D. Johnson, DDS, MS of any changes in my personal or medical status. I authorize Stacy D. Johnson, DDS, MS or qualified designate to perform dental services that I may need during diagnosis and treatment with my informed consent. If the patient is a minor, I certify I am the legal guardian and consent to treatment on their behalf.

Patient Name_____Date:_____

Signed_____Date:_____

My Signature confirms I am legally the Responsible Party, Parent or Authorized Guardian for the patient listed above.