Archana M. Johnson, DDS, PC
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# FINANCIAL AGREEMENT

Thank you for choosing our practice for your dental care. Our team is committed to your overall health and the success of your treatment, please understand that payment of your bill is considered a part of your commitment to treatment.

## ABOUT OUR FEES

Just as we are committed to providing you with the very best dentistry has to offer, so are we committed to making dentistry financially comfortable for you. We will review your payment options with you before any treatment is begun. To accommodate you, we accept cash, checks, Visa, Mastercard, and American Express. ***We extend a 7% courtesy to patients without dental benefit for payment in full by cash, check, or charge three (3) days before a scheduled appointment.***

## INSURANCE/DENTAL BENEFITS

We will accept assignment of your insurance benefits. However, we do require YOUR CO-PAY & DEDUCTIBLE BE PAID IN FULL AT THE TIME OF SERVICE. Any balance is your responsibility whether your insurance company pays for your treatment or not. We will gladly process your insurance claims. It is important that you understand that your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable or customary by your insurance company under the policy your employer has selected. If your insurance company does not cover a service this it is your financial responsibility.

## MISSED OR LATE APPOINTMENTS

Please help us serve you and our other patients better by keeping scheduled appointments and times. Appointments that are missed or changed at the last minute are then unavailable to patients who need appointments. Missed or appointments canceled with less than 24-hour notice are subject to a cancellation fee. Please consider your schedule carefully when making appointments.

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Thank you for taking the time to read our financial agreement. Our team is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our Patient Care Coordinator would be glad to review our financial agreement with you.

**PAYMENT OPTIONS** (PLEASE CHOOSE ONE)

o CASH o CHECK o CREDIT CARD o FINANCING OPTIONS

I have read and understood Dr. Johnson's financial agreement and agree to the above arrangements.

**FINANCE CHARGE:** If I do not pay the entire balance within 60 days of the treatment date a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month, which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any interest on the balance due, together with any collections costs and attorney's fees incurred to effect collection on this account.

***Signature:*** ***Date:***