Johnston Family Dentistry
6108 NW 59th Ct.
Johnston, IA 50131

PATIENT FINANCIAL AGREEMENT

PATIENT FINANCIAL AGREEMENT: The undersigned Patient or Responsible Party ("Patient") agrees to the following terms regarding payment for professional services rendered by Johnston Family Dentistry ("Doctor"):

RESPONSIBILITY FOR PAYMENT: Patient acknowledges and agrees that they are ultimately responsible for the **full cost of all treatment rendered**, regardless of insurance coverage. While we may assist you in filing insurance claims, the contract for insurance is between the Patient and the insurance carrier.

INSURANCE UNDERSTANDING: It is the Patient's responsibility to understand their specific dental insurance coverage. This includes, but is not limited to: covered and non-covered procedures, annual maximums, deductibles, co-payments, and waiting periods. The Doctor's office provides estimates as a courtesy, but they are not a guarantee of payment by your insurance company.

PAYMENT AT TIME OF SERVICE: All estimated co-payments, deductibles, or full payments for non-covered services are **due at the time of service** (or prior to treatment for major procedures as determined by the Doctor).

CREDIT CARD ON FILE: Patient agrees that a valid credit card may be kept on file. By signing this agreement, Patient authorizes the Doctor to automatically bill the card on file for any outstanding balance that remains unpaid **30 days** after the date of service, including any balances remaining after insurance has processed.

BILLING AND FINANCE CHARGES: Patient agrees to pay any remaining balance in full within **30 days** of the billing date. **Finance Charges:** If the balance is not paid within **30 days**, a **FINANCE CHARGE** of 1% per month (12% APR) shall be applied to the portion of the account that remains unpaid after 30 days.

RETURNED CHECKS AND COLLECTION COSTS: Returned Checks: A fee of **$35.00** will be charged to the account for any check returned by the bank for non-sufficient funds (NSF). **Collection Costs:** In the event that this account is referred to a collection agency or attorney, the Patient agrees to pay all costs of collection, including reasonable attorney fees and collection agency commissions.

MINORS AND DIVORCE DECREES: The parent or guardian who brings a minor child to the office for treatment is responsible for payment at the time of service. This office will not participate in or mediate disputes resulting from divorce decrees or court orders. Any reimbursement between parents must be handled privately.

RIGHT TO REFUSE SERVICE: Doctor reserves the right to refuse to render future services (excluding emergency care as required by law) until all outstanding balances have been paid in full.

ACKNOWLEDGMENT: The undersigned Patient or Responsible Party acknowledges that they have read and understood this information. A copy of this statement is available upon request.

Patient Name: _____

Responsible Party Signature: _____

Date: _____