DRS. JOHNSON & JOHNSON
2204 ITHACA AVE, STE B
LUBBOCK, TX 79410
806-793-4438

**PLEASE READ CAREFULLY **

FINANCIAL AGREEMENT AND INSURANCE COVERAGE

RESPONSIBLE PARTY_____ EMPLOYER _____
SPOUSE'S NAME _____EMPLOYER_____
HOME PHONE # _____WORK PHONE # _____

PLEASE CHECK ALL METHODS OF PAYMENT THAT APPLY FOR YOUR DENTAL CARE

___I DO NOT HAVE DENTAL INSURANCE. I CAN PAY ____CASH, ___CHECK, ____BANK CARD (VISA, MC OR DISCOVER CARD), ON EACH VISIT AS TREATMENT PROGRESSES.
____I HAVE DENTAL INSURANCE, INS. CO. NAME AND POLICY NUMBER
_____

I WILL PAY MY DEDUCTIBLE OF$_____ PLUS NAY PORTION OF THE COSTS MY INSURANCE DOES NOT PAY ON EACH VISIT-DEPENDING ON THE DENTAL PROCEDURES, (FILLINGS, EXAMINATION, CLEANING AND ROOT CANALS.)

ON EXTENSIVE TREATMENT, I WILL NEED TO MAKE FINANCIAL ARRANGEMENTS. I WILL HAVE TO FILL OUT A CREDIT APPLICATION AND IF MY CREDIT IS APPROVED (IT TAKES 10-15 MINUTES TO SUBMIT THE INFORMATION.) MY PAYMENT WILL BE ON A MONTHLY BASIS ACCORDING TO WHAT MY BALANCE IS.

ON EXTENSIVE TREATMENT SUCH AS CROWNS, BRIDGES, PARTIAL DENTURES, AND DENTURES, THESE SERVICES MUST BE PAID OFF BEFORE THEY ARE RECEIVED. IF YOU HAVE INSRANCE YOUR PART WILL HAVE TO BE PAID IN FULL.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CAOSTS NOT PAID BY MY INSURANCE COMPANY WITHIN 45 DAYS FROM THE LAST DATE OF MY TREATMENT. I CONSENT THAT THE SIGNATURE BELOW MAY BE KEPT ON FILE FOR THE SUBMITTAL OF ANY CLAIM FORMS PERTAINING TO MY FAMILY'S DENTAL TREATMENT. I ALSO UNDERSTAND THE INFORMATION EXPLAINED IN THIS AGREEMENT

SIGNED_____DATE_____

DRS. JOHNSON & JOHNSON, D.D.S., L.L.P.
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LUBBOCK, TX 79410
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SECTION A
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

NAME:_____
ADDRESS:_____
TELEPHONE:_____E-MAIL:_____
SOCIAL SECURITY NUMBER:_____

SECTION B
I _____ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES FROM THE ABOVE NAMED PRACTICE.

SIGNATURE:_____DATE:_____
IF PERSONAL REPRESENTATIVE SIGNS THIS AUTHORIZATION ON BEHALF OF THE INDIVIDUAL, COMPLETE THE FOLLOWING:
PERSONAL REPRESENTATIVE'S NAME:_____
RELATIONSHIP TO INDIVIDUAL:_____

SECTION C
GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT

DESCRIBE YOUR EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT ON THIS FORM:_____

DESCRIBE THE REASON WHY THE INDIVIDUAL WOULD NOT SIGN THIS FORM:_____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT.

_____
OFFICE WORKERS SIGNATURE: DATE

_____
PRINT NAME TITLE