

FINANCIAL AGREEMENT

Payment is required for services rendered at the time of that treatment!

Method of Payment: ___ Cash ___ Check ___ Credit Card (MC or Visa) ___ Care Credit/AFS
Insurance Co. Name _____ Address _____
City _____ State _____ Zip Code _____ Phone # _____
Policy # _____ Group # _____ Employer _____
Name of Subscriber _____ Soc. Sec # _____ DOB _____

The policy of our office is that the parent who brings the child for treatment is responsible for all fees for treatment/services rendered.

Financial Agreement:

I understand that I am responsible for the payment of all fees for dental treatment for the patient named on the reverse side. I understand that I am responsible for any fee not paid by the patient's dental or medical insurance. The undersigned agrees: should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Print Name

Print Name

Signature

Signature