SWISHER & ASSOCIATES
TOTAL DENTAL CARE

Financial Agreement

Last Name: First Name: Birthdate:

For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

Treatment plans may change, and I will be responsible for the work actually done.
I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.

I understand that any copays, fees for treatment, or lab charges less than $300 are due and payable at the time treatment is rendered. We accept cash, personal checks, or credit cards.
I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.

I will pay a fee of $25 (hygiene) or $50 (restorative/emergency) for appointments broken without 24 hours notice.

If sent to collections, I agree to pay all related fees and court costs.

Patient Signature:

X_____

Date: