Financial Agreement

Patient Name: _____ DOB: _____ Date: _____

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

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

Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.

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 for appointments broken without 24 hours notice.

Treatment plans may change, and I will be responsible for the work actually done.

_____

Patient, Parent, or Guardian Signature