Financial Agreement

Last Name: First Name: Birthdate:

Date:

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* 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 after 30 days, I will still be responsible for the remaining balance.
* 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 LESS THEN 24 hours notice of $50.00. I understand when I schedule an appointment a room is reserved for me and if I can not make my appointment as a courtesy is my responsibility to cancel in 24-48 hours to allow services for another patient in need.
*After multipe missed appointments the office can release you from being seen for future appointments.
*We vaule our patient's time and expect the same in return so if you are running late for an appointment please call our office and make us aware or when you show up you might need to be rescheduled. If you are more then 15 minutes late to your appointment and we have not heard from you then we will need to reschedule your appointment to avoid running in to the next patients reserved appointment.
* Treatment plans may change during procedures, and I will be responsible for the work actually done.

I agree to let this office run a credit report. If no, then all fees are due at time of service.

☐ Yes

☐ No
