FINANCIAL AGREEMENT

***If you have Dental Insurance, please fill out both Sections 1 and 2. Otherwise, skip to Section 2.

SECTION 1

Primary Dental Insurance Information

Insurance Company_____ Phone Number _____

Mailing Address _____

Group Name _____ Group Number _____

Relationship to the Primary Member: Self _____ Spouse _____ Child _____ Other _____

Name and Date of Birth of Primary Member _____

Member ID Number _____

Secondary Dental Insurance Information

Insurance Company_____ Phone Number _____

Mailing Address _____

Group Name _____ Group Number _____

Relationship to the Primary Member: Self _____ Spouse _____ Child _____ Other _____

Name and Date of Birth of Primary Member _____

Member ID Number _____

SECTION 2

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless prior arrangements have been made. In the event payments are not received by the agreed upon date, I understand that a 1-1.5% late charge (18% APR) may be added to my account. If required, I understand a check of my credit history or processing to collections may be made.

I understand that 48 business hours is required for cancellation or rescheduling of appointments. I understand a cancellation fee or deposit may be applied for broken appointments.

Patient's signature and date: _____