FINANCIAL AGREEMENT STATEMENT

I, The Undersigned, hereby agree to pay the above named dental practice all fees due for services rendered. Payment is to be made at the time of service regardless of insurance coverage.

I understand that payment of my bill is my legal obligation as the patient. All filing of insurance papers and confirmation of insurance payments to be made by my insurance carrier are my responsibility, as is determining providers covered by my current insurance. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow through or confirmation.

If this account is placed in the hands of an attorney for collection, I agree to pay attorney fees of thirty three and one third percent (33 1/3%) of the unpaid principal and interest owing, plus all court costs and interest. Interest is charged at the rate of one and one half percent per month (18% APR), beginning 30 days after the monies have become due or expenses have been incurred.

I also agree that this agreement shall cover all services for my spouse and any dependents and will remain in full force and effect until revoked by me in writing.

I further agree to pay returned check charges of $30 per returned check.

Patient signature or Responsible Party: _____

Date: _____