

## 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, 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.