

## 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.

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

Yes

No