Financial Statement

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

A financial charge of 1.5% per month equal to an annual percentage rate of 18% per annum will be added to any unpaid balance of 90 days or more past due.

We always prefer that you keep your appointment but if you are unable to do so kindly give us 24 hours notice. Failure to give us 24 hours notice may result in a $25 cancellation fee.

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Signature (if minor parent or guardian's signature) Date