EAST WICHITA DENTIST

FINANCIAL AGREEMENT

First Name: _____ Last Name: _____

DOB: _____

- For my convenience, this office may release my information to my insurance 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.
- As a courtesy to me, this office will file my dental insurance claim for me. If my insurance does not pay as expected, I agree to be responsible for any balance due.
- If my account becomes 90 days past due, the account may be handed over to our collection agency. I agree to be responsible for all costs of the collection process, as well as my portion of the dental services provided to me.
- I understand appointments need to be broken with a 24-hour notice. I agree to pay a $50 broken appointment fee upon the third broken appointment.
- It is not uncommon for a treatment plan to change during a procedure. I understand I will be informed if there is a need for a change and I agree to be responsible for the work actually completed.

Signature: _____

Date: _____