McDonald Family Dentistry

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 understand that any appointment time made for me is a reservation set aside for me, and that if I break my appointment without 24 hours notice I am preventing another person from being able to be seen and may be charged a broken appointment fee of $50.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature: _____