



FINANCIAL AGREEMENT

Responsible Party: _____

Home Phone: (____) _____

Employer: _____

Work Phone: (____) _____

Spouse's Employer: _____

Work Phone: (____) _____

Please check *all methods* of payment that apply for your dental care.

I DO NOT HAVE DENTAL INSURANCE

I can pay by: Cash Check Bankcard (Visa, MasterCard or Discover), on each visit as treatment progresses.

I need to make financial arrangements in order to have small monthly payments. I understand that I must fill out a credit application and that monthly finance charges may be involved.

I HAVE DENTAL INSURANCE

Company Name/ Policy #: _____

I elect to pay my deductible of \$ _____, and any portion of the costs my insurance does not pay *on each visit* by:
 Cash Check Bankcard (Visa, MasterCard or Discover)

On extensive treatment, I need to make financial arrangements in order to have small monthly payments. I understand that I must fill out a credit application and that monthly finance charges may be involved.

For Office Use Only: Cat. 1 ___% Cat. 2 ___% Cat. 3 ___% Ded. _____ Yearly Maximum _____
Ded. Apply to Preventive Y N

I realize that my insurance benefits can only be *estimated* and that no insurance company will pay *all* treatment costs. I understand that I am responsible for all costs not paid by my insurance company within 45 days of the insurance claim submittals, and that interest accrues on my account after this time.

Date: _____ Signed: _____

I consent that the above signature may be kept on file for submittal of any insurance claim forms pertaining to my family's dental treatment