



FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

Patient's Name(s) _____

I authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment at the time of service, unless arrangements have been made in advance.....
(Initials)

I realize that if I have dental insurance, that it is a supplement and should not dictate my course of treatment. If a procedure is performed that is not a covered benefit, I will be responsible for the fee.....
(Initials)

If I have dental insurance, it is my responsibility to know what my coverage and benefits are. Northwest Smiles will check upon request but I am ultimately responsible for knowing what my insurance will and will not cover.....
(Initials)

I will pay a \$25 fee for returned checks.....
(Initials)

If my account falls delinquent over 90 days it will be turned over to a collection agency if deemed absolutely necessary.....
(Initials)

Failure to show up for an appointment or late cancellation (without 24 hours notice) will result in a no show or late cancellation fee of \$50 charged to my account.
I will not be able to be reappointed until I have paid this fee.....
(Initials)

Signature of Person Responsible for Payment

Date