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)

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Signature of Person Responsible for Payment **Date**