TOMCHIK DENTISTRY
4624 PEMBROKE BLVD. SUITE 103
VIRGINIA BEACH, VA 23455
757-460-2250

FINANCIAL AGREEMENT

PLEASE READ THIS AGREEMENT CAREFULLY

I, _____ (patient/responsible party), understand that my insurance is an agreement between the insurance company and myself.

I understand that **Tomchik Dentistry** will file my insurance for services rendered as a courtesy as long as I have provided all of my insurance information needed to do so. I am fully responsible for any payments due that are denied by my insurance company. If the services rendered are not paid within sixty (60) days by my insurance company, I am responsible for the balance on the sixty-first (61st) day.

I assign payments to be made on my behalf to this provider for any services rendered to me. I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services.

All fees/co-payments are due on the day of treatment unless other arrangements have been made in advance. All accounts overdue more than 60 days are subject to 1.5% per month finance fee (18%APR).

In the event fees are not paid as requested, a collection agency and possibly legal action may follow. If so I, _____ (patient/responsible party), will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

APPOINTMENT AGREEMENT

Your appointment is a commitment of time between you and our office. If you are unable to keep your appointment we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If we do not receive 24 hour notice you may be charged a broken appointment fee up to $100.

I have read and understand this financial agreement.

Patient/Responsible Party Name: _____

Signature: _____ Date: _____