Patients Name___________________________

FINANCIAL AGREEMENT

Payment in full for all charges is required at the time of visit, unless prior arrangements have been made.

INSURANCE FILING

The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign directly to Erickson Pediatric Dentistry & Orthodontics P.C. dental insurance benefits for any and all dental work done by Dr. Erickson and/or his support staff. I further authorize Erickson Pediatric Dentistry & Orthodontics P.C. to release, to my insurance company, any and all information relating to the submittal of dental insurance claims.

________________________________ ________________________________
Responsible Party Signature Date

DELINQUENT ACCOUNTS

All delinquent accounts (30 days or older) may be subject to reasonable service charges and/or legal interest rates.

FAILED APPOINTMENTS

Failed appointments (less than 48 hours notice) are a significant contributor to rising dental and health care costs. Individuals who fail to show for a confirmed appointment may be assessed a fee based on the length of the missed appointment.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

________________________________ ________________________________
Responsible Party Signature Date

________________________________ ________________________________
Witness/Title Date