



AMANDO DENTAL

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I acknowledge that all financially responsible parties are to be present for all treatment planning and financial estimates. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. In the event my account balance remains unpaid in excess of 90 days, I understand that my account will be turned over to a collections agency. I accept full responsibility for all administrative costs and legal fees associated with the collections process.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and assign directly to Amando Dental all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance *within 30 days from the date of service*. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I understand that Amando Dental has a broken appointment policy and I will be charged \$40, unless I notify the office within 2 business days of my cancellation. Amando Dental is not open Friday, Saturday, or Sunday. These are not business days.

For your convenience our office takes personal checks. However, I understand a \$50 fee will be applied to my account for a bounced check (NSF) and from that point forward, personal checks will no longer be acceptable form of payment.

Signature

Date