Dr. Robert Rosswog

NEW PATIENT FINANCIAL AGREEMENT FORM

Date: _____

Patient Name:_____

(Parent or Guardian)

Person responsible for account:_____

METHOD OF PAYMENT

Please check one of the following:

___ Payment in full at each appointment

___ Co.-payment in full at each appointment

___ Credit Card

___ Care Credit (Payment Plan upon approval)

I understand that I am responsible for all Fees incurred for my dental treatment. Most insurance plans are payment assistance plans, they are not designed to cover the entire costs of treatment. I understand that my dental insurance carrier may pay less than the actual bill for services. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information listed is correct to the best of my knowledge.

***Any account balance over 60 days will incur a 1.5% finance charge. Additional charges may occur if the account is turned over for collection.**

SIGNATURE OF RESPONSIBLE PARTY

X_____Date _____

State Driver's License Number: _____

___ Adult Patient ___ Parent ___Spouse ___Guardian