



STEDDUM

FAMILY & RESTORATIVE
DENTISTRY

Financial Agreement

Patient Information

Patient name: _____ DOB: _____

Payment Agreement

I agree that I am responsible for all the services rendered to the patient and that payment is due and payable to Steddum Family & Restorative Dentistry (the Practice) at the time services are rendered. I understand that health, dental and accident insurance policies are an arrangement between my insurance carrier and the patient. I agree to pay all deductible and co-pays at the time of service. If I have dual insurance, my co-pay or deductible will be based on the primary coverage. I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to my treatment that I will pay in full for the services at the time they are rendered.

I understand the Practice may charge me for the following items:

1. For each returned check, a fee of \$35, but not to exceed the maximum amount permitted by law.
2. A late fee if payment on my account is not received by the due date.

I agree to the extent permitted by law that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

Responsible Party

Please print and sign as the financially responsible party, even if the patient is also the responsible party.

Responsible Party (Print)

Signature of Responsible Party

Date