Financial Agreement Form

Last Name: ______________________ First Name: ______________________ Birthdate: ______________________

We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage; your insurance policy is a contract between you and your insurance company. We cannot guarantee payment or coverage of your claim.

I agree to pay all fees and charges for services rendered at Coral Kids Dentistry for myself and my family. I agree to pay all charges when presented with a statement, unless prior credit arrangements are agreed upon in writing.

I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balance on my account.

A parent or legal guardian must accompany all minors to their dental appointments. The parent or guardian accompanying the child is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for full payment, without any exception. We will not attempt to collect payment from a parent that is not present in the office at that visit.

Financial Arrangements:

☐ Cash ☐ Credit Card ☐ Debit Card ☐ I would like to discuss the office's payment policy

Responsible Adult:

Name: ______________________________

Driver's Licence # : ______________________________

Date of Birth: ______________________________

I agree to let this office run a credit report. If no, then all fees are due at time of service.

☐ Yes
☐ No

Patient/Parent/Guardian Signature: ______________________________ Date: 2021-03-04