## **FINANCIAL AGREEMENT**

| Date:   | Name:                     | Dr:                               |                       |
|---|---------------------------|-----------------------------------|-----------------------|
| Description:  |                           |                                   |                       |
| Description:  |                           |                                   |                       |
|   |                           |                                   |                       |
|   |                           |                                   |                       |
| Fee:  |                           |                                   |                       |
|   |                           |                                   |                       |
|   |                           |                                   |                       |
|   |                           |                                   |                       |
| Total Fee:  |                           |                                   |                       |
| Insurance Pay                                       | ments: (if applicable)    |                                   |                       |
| Percentage: _                                       |                           |                                   |                       |
| Total Expecte                                       | d:                        |                                   |                       |
| Patients Resp                                       | onsibility:               |                                   |                       |
| Denosit:  |                           | Date Due:                         |                       |
| •   |                           | Date Due:                         |                       |
| balance:  |                           | Date Due:                         |                       |
| Terms: (if app<br>I accept full re<br>investigation | esponsibility for the fir | nancial arrangements stated above | e; I authorize credit |
| Patients Signa                                      | ature:                    |                                   |                       |

