FINANCIAL AGREEMENT

Date: _____ Name: _____ Dr: _____

Description: _____

_____

_____

_____

Fee: _____

_____

_____

_____

Total Fee: _____

Insurance Payments: (if applicable)

Percentage: _____

Total Expected: _____

Patients Responsibility: _____

Deposit: _____ Date Due: _____

Balance: _____ Date Due: _____

Terms: (if applicable)
I accept full responsibility for the financial arrangements stated above; I authorize credit investigation if required.

Patients Signature: _____

stone mason DENTAL

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