Dr. Robert Anderson
3775 Stockton Hill Rd., Ste C
Kingman, AZ 86409

FINANCIAL AGREEMENT

Last Name	First Name	Birthdate

IF YOU HAVE A DEDUCTIBLE WITH YOUR INSURANCE COMPANY IT IS DUE AT TIME OF SERVICE.

For my convenience, Robert Anderson D.D.S. may release my information to my insurance company and receive payment directly from them.

I understand that if I begin major treatment that involves lab work, I will be responsible for the lab fee at that time.

If sent to collections, I agree to pay all related collections fees and court costs.

Every effort will be made to help me with my insurance, but if insurance does not pay as expected, I am aware I will be responsible for any balance on my account.

I agree to pay finance charges of 1.5% per month (18 % APR) on any balance 90 days past due.

I will pay a fee of $50.00 for appointments broken without prior notice.

We make every attempt to diagnose and treatment plan what is in the best interest for the patient. **In the event my treatment plan changes I am aware I will be responsible for the work actually done.**

Patient Signature	Date