Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy. I understand that dental services furnished to me are charged directly to me and I am personally responsible for payment of all dental services. If I have dental insurance, I authorize and request my insurance company to pay directly to Michael Scrydloff DDS Inc.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

- **Patients with insurance**: The patient is responsible for the estimated non-covered portion, and /or deductible at the time of the service. If the insurance company does not pay after 60 days, we ask that you make the remaining payment while we work together to get the insurance company to fulfill their obligations.

- Parents not accompanying their child to an appointment must make prior arrangements for payment.

18% interest is charged for any unpaid balance after 60 days. There is a $30.00 processing charge for non-sufficient funds or returned checks.

I,_____, agree and authorize to these financial terms.

Signature_____Date_____