Roseville Dental Center
1771 Pleasant Grove Blvd, Ste. 180 Roseville, CA 95747
(916)772-3847

Financial Agreement

Patient Name:_____________________

Birthdate:_____________________

* For my convenience, this office 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 fee at that time.

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

* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.

* 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 for appointments broken without 48 hours notice.

* Treatment plans may change, and I will be responsible for the work actually done.

My signature below signifies I understand I am responsible for all fees at time of services

Signature____ Date:______________