METROPOLITAN DENTAL CENTRE

The Center For Comprehensive Dental Care

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that as a patient, parent, guardian or personal representative, I am responsible for ALL fees and services rendered. I understand that filing a claim with my insurance company DOES NOT relieve me from my responsibility for the payment of all charges. Insurance claims are filed by this office as a courtesy and payment will be made directly to the patient**. Accounts over 60 days will have a 10% interest rate applied monthly until the balance is paid.**

Responsible Party Signature | Printed Name of Responsible Party

Relationship | Date