

Each patient, NOT THE INSURANCE COMPANY, is responsible for payment to this office within the useful terms of our policy.

I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and Flagstaff Dental Arts. Our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. If there is an open balance, a statement will be sent to you.

I am fully responsible, regardless of benefits, for all dental fees.

I understand that all services are payable at the time of service unless prior arrangements are made with Flagstaff Dental Arts. Any balance due past the end of the month may be subject to a finance charge computed at 12% per annum.

All returned checks are subject to a \$30 returned check fee.

I agree to pay all costs and expenses incurred should this account be turned over to an attorney, collection agency, or any action through the legal system for collection, including attorney fees, collection agency fees, court costs, and interest.

Agreed by:

Signature:

Date: