Miracle Dental Associates, LLC

Financial Agreement

Last Name: First Name: Date of Birth:

- For my convenience, this office may release my information to my insurance company and receive payment directly from them.
- If my account is delinquent, I may be sent to collections, and I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if insurance does not pay as expected, I will still be responsible for any outstanding balances.
- I will pay a fee of $25.00 for any single appointment broken without 48 hour notice.
- Treatment plans may change, and I will be responsible for the work actually done.

Patient / Guardian Signature: Date: