FINANCIAL AGREEMENT

I understand that all payments are due on the day the service is rendered.

FINANCIAL AGREEMENT AND GUARANTEE OF PAYMENT

In consideration of services and care rendered for today's visit and all future visits, I agree that I am responsible for any and all charges billed by Everett Endodontics and I understand that all payments are due on the day the service is rendered. I understand that Everett Endodontics will bill my insurance carrier directly and will accept assignment on covered services but I agree to pay deductibles, coinsurance and non-covered services, as determined by my insurance carrier. Upon receipt of a statement from Everett Endodontics, I agree to pay all amounts not covered by insurance immediately. In order to avoid increased fees to all patients, Everett Endodontics will take the following actions:

- ANY ACCOUNT BALANCES OVER 30 DAYS WILL BE ASSESSED A FEE OF 1.25% OF THE BALANCE DUE PER MONTH.
- ALL ACCOUNTS OVER 90 DAYS WILL BE NOTIFIED IN WRITING OF THEIR ACCOUNT BEING TRANSFERRED TO A COLLECTION AGENCY.
- THERE WILL BE A FEE OF $25.00 ASSESSED TO ALL ACCOUNTS FOR RETURNED CHECKS.

If I make a change to my insurance coverage, I understand that it is my responsibility to notify Everett Endodontics of this change.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE POLICY OF EVERETT ENDODONTICS.

_____

(Printed Name of Patient or Authorized Representative)

_____

(Signature of Patient or Authorized Representative) (Date)

Note: If patient is under the age of 18, the signature of a parent or guardian is required.