Lake Hills Dental Care
ERIC S SMITH, DDS
3901 FM 2181
Suite 100
Corinth, TX 76210
P: (940) 321-2340
F: (940) 321-2394

Financial Agreement Form

Patient's Name: ____

Payment Agreement:

I agree and understand that I am responsible for all services rendered and that payment is due and payable to the Dental Practice at the time services are rendered. I understand that health, dental and accidental insurance policies are an arrangement and contract between the insured and the insurance carrier. I understand that the Dental Practice will file claims with my insurance company on my behalf, as a courtesy, and understand that I am responsible for any and all balances not paid by my insurance company. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that the Dental Practice may charge:

1) a late fee if a payment on my account is not received by the due date;
2) An amount equal to $35.00, but not to exceed the maximum amount permitted by law, for each returned check;
3) A fee for each appointment that is missed / canceled without at least 24 hours advanced notice.

I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or cost relating to the collection proceeding, including court cost. I authorize payment directly to the Dental Practice.

Responsible Party:

Full Name: ____

SSN: ______________________________ Phone: ___________________________________

Address: ____

Signature: ____ Date: ______________