Grosso Family Dentistry

FINANCIAL AGREEMENT

Financial Responsibility

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts may be subject to collection and billing fees. I will be held responsible for all collection costs incurred by the dental office.

Regarding Appointments

Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment so we ask that you kindly give us a minimum of 1 business day notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. Any appointment that is broken without a business day notice, is subject to a cancellation fee of $50 and if necessary, all future appointments may be cancelled.

We also realize that temporary financial situations may affect timely payment/s of your account. If a circumstance does arise, we encourage you to contact us promptly for assistance in the management of your account.

I have read the Grosso Family Dentistry Financial Agreement. I understand and agree to this Financial Agreement. Please let us know if you have any questions or concerns regarding this agreement.

Thank you for understanding our Financial Agreement.

Patient/Legal Guardian Signature:_____ Date:_____

Printed Name of Patient/Legal Guardian: _____