Olympia Dental Group
6050 Pacific Ave E
Lacey, WA 98503
360-943-4777

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

Patient's Name:_____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown on my statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due after dental services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper.

It is agreed that payments won't be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

NOTICE: Do not sign this agreement before you read and agree to the conditions. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

NOTE: All account balances over 60 days will be charged a 2% MPR. Missed appointments without 24 hours prior notice will be charged $50.00. I authorize Olympia Dental Group to duplicate my records upon request.

Signature_____ **Date**_____