FINANCIAL RESPONSIBILITY

I, ____, understand that all services are to be paid at time of service unless specific arrangements have been made. I also understand that this waiver is good for any and all visits with this practice now and in the future.

It is my responsibility as the patient to update this office of any address changes for billing purposes, as well as any changes in dental insurance for proper claims processing.

I understand that in the event that my account reaches 90 days past due for nonpayment, I will be held responsible for any collection fees Smile Center Memphis, P.C. incurs.

We file dental insurance as a courtesy to you. We are not responsible for what the insurance company does or does not pay.

____

Patient's Signature or Guarantor if Minor Date

Thank you

Smile Center Memphis, P.C.