

Financial Policy

I have read and understand the Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above. I understand that the terms of this Financial Policy may be amended by the practice at any time with or without notice to me.

PLEASE LIST ALL CHILDREN IN THE FAMILY

Patient's Name (s):

Date of Birth

Responsible Party's Name

Relationship to Patient

Responsible Party's Signature

Date

On completion, we will provide you with a copy of this policy for your records.