

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

Patient name: _____

Practitioner name: _____

I _____ agree to pay all fees and charges for evaluation and treatment for the person named above until the patient turns _____ years of age on _____.

I agree to pay all charges promptly unless credit arrangements are agreed upon in advance. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date.

NOTICE: You are entitled to a copy of this agreement.

Signature: _____ Date: _____
Person Responsible for Payment

Bill to address: _____

Message Phone number: _____