Southwest Dental Center, LTD.
Financial Agreement

Welcome to Southwest Dental Center. Our professional staff is committed to your treatment being successful. The following is a statement of our financial policy, which we require you read and sign prior to receiving treatment.

I hereby authorize the release of pertinent dental information to my insurance carriers. I am aware that dental insurance coverage varies and, while insurance carriers may use such terms as customary, reasonable, prevailing, ETC. To limit their coverage, I am ultimately responsible for payment of all charges for services rendered by the dentist at Southwest Dental Center.

I understand if I fail to keep a schedule appointment I will give 24 hours notice of cancellation. A missed appointment charge of $35 will be applied to my account.

Our office accepts Visa, MasterCard, Care Credit and Discover as a form of payment.

I understand that I am solely responsible for all costs in the event that my account is turned over to a collection agency including attorney's fees and interest charges.

I have read and fully understand that Patient Financial Agreement as outlined above

I understand that this is authorization shall apply to all services provided to me, dependents, or any other person for which I have assumed responsibility for by signing below.

Patient: ______________________ Date:

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