Financial Agreement

I authorize my treatment or treatment of the patient. I agree to pay all fees and charges for such treatment the day they are incurred unless previous arrangements have been made. I understand balance is due in full at each statement. If payment on any balance is delayed, we reserve the right to impose a finance charge computed at the rate of **1% monthly** on any outstanding balance.

It is agreed that payments will not be delayed or withheld because of any pending insurance coverage. All proceeds of insurance are assigned to the doctor where applicable, but without the doctor assuming responsibility for the collection of those claims.

If insurance does not pay your claim within 60 days after it is sent, we ask that you pay the balance of your account and that you contact your insurance company regarding settlement.

Signature: _____ **Date**: _____

WRIGHT DENTAL GROUP