Erramouspe Dental Financial Agreement

I have received a copy of the Erramouspe Dental Financial Policy, and have read and understand my financial obligations.

- I understand that I am responsible for all debts incurred, whether I have dental insurance or not.
- I understand that some charges may not be covered by my insurance.
- If my account is assigned to a collection agency, I understand that I am responsible for attorney fees or court costs that may be incurred during the collection of my debt.
- I authorize the doctor to release all information necessary to secure payment of benefits.
- I authorize the use of this signature on all insurance claims.

Signature: _____ Date: _____

Print Name: _____