PREMIER
DENTAL GROUP OF KNOXVILLE
A Lifetime of Smiles

Phone: 865-637-5708
Fax: 865-637-5712

Cover Kids Financial Agreement

Date: _____

Patient Name: _____

Financial Responsible Party: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Cost of Initial Treatment	$_____
Initial Payment	- _____
Approximate Insurance Payments	- _____
Amount Remaining by Patient	- _____
Deband Amount by Patient	- _____

Amount due to be paid in _____ monthly payments of $ _____ starting _____.
Balance to be paid in full by _____.
Starting on the 1st (first) orthodontic adjustment appointment.

I understand the financial arrangement set forth by Cover Kids and Premier Dental Group, PLLC of Knoxville. I agree that the parent/parents are responsible for all fees and services rendered for treatment of child. I understand that once Cover Kids pay the set forth amount of the contract is as reads and this a binding agreement.

Signature of Parent/Legal Guardian _____ Date _____

Witness _____ Date _____

Premier Dental Group, PLLC of Knoxville
303 South Concord Street Suite 323
Knoxville, TN 37919