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

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 Due From Patient	= _________________________

Amount due to be paid in ____________ monthly payments of $ _______________ starting ___________________.
Balance to be paid in full by ____________________.

I understand the financial arrangements above and agree to comply with them; I agree that I am responsible for all fees and services rendered for treatment of my child. I understand that I am responsible for <u>ALL</u> fees regardless of insurance coverage. I also understand that as treatment progresses the above fees may have to be adjusted, but that I will be informed of these adjustments and how they affect my payment plan. My monthly payments must be paid <u>AT EACH VISIT</u> unless other arrangements have been made and approved by management. I agree to pay ALL costs of collections, including, but not limited to, reasonable attorney's fees, and court fees. By signing this document you agree to the terms above, this is a legal and binding document.

Signature of Patient ____ Date ________

Signature of Parent/Legal Guardian _________________________________ Date ________

Witness ____ Date ________

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