FINANCIAL AGREEMENT
AND
AUTHORIZATION FOR TREATMENT

Dr. Joseph C. Elkins

By virtue of my signature below - I authorize treatment of patient _____ and agree to pay and otherwise held responsible for all fees and charges for all dental treatment at the time dental services are provided.

To the extent that credit arrangements are agreed up **IN WRITING IN ADVANCE OF TREATMENT**, I agree to comply with any such credit arrangements relating to me and/or any members of my family. In the event legal action should become necessary to collect any unpaid balance for dental services provided to me and/or my family - I/we agree to pay reasonable attorney's fees and related costs with regard to the collection of any such unpaid balance.

I agree that I am responsible for **ALL** charges incurred by me and/or my family whether or not such charges are otherwise covered by Insurance. I further agree that payment of such charges by me will not be delayed or withheld by me because of any Insurance coverage or the pendency of claims thereon and that all proceeds of Insurance are assigned to this office without this office assuming responsibility for the collection thereof.

I agree that a service charge of 1% per month (12% per annum) will be added to all unpaid balances for my account or that of my family. _____

I acknowledge that the information above is for the purpose of my obtaining credit and is warranted by me to be true and correct. I authorize Dr. Joseph C. Elkins, Jr. or his agent, to make an investigation of my credit including, but not limited to, verification of my employment.

I have read all the above information and understand and agree that regardless of my Insurance status that I am fully responsible for the balance of my account, and that of my family, for any and all dental services and treatment provided by this office.

I hereby acknowledge receipt of a copy of this document.

Signature: _____ **Date:** _____