# PATIENT FINANCIAL AGREEMENT

Date: _____

I understand that I am responsible for payment of all charges for services received at the offices of **J. Perry Fikes, D.D.S., P.C.** today and in the future.

*(Please choose the option that best suites your situation.)*

☐ I do not have insurance. I will pay my balance in full at the time of service. I will pay

☐ Cash, **in full**, at time of service and receive a 10% courtesy.

☐ Check, **in full**, and receive a 10% courtesy.

☐ I have dental insurance that I would like you to file. I understand that I am responsible for all charges regardless of whether or not insurance coverage applies. Please file a claim with my insurance company. I will pay all deductibles and estimated non-covered charges and/or co-payments at time of service using the following option:

☐ Cash

☐ Check

☐ Credit card. Please pay all estimated non-covered amounts and, after insurance pays, pay all unpaid balances using the following credit card information and mail me a receipt.

_____ _____ _____
Credit card type Credit card # Exp. Date

_____ _____
Print Name (as it appears on card) Signature

☐ I wish to pay my balance in **3 equal monthly payments** using the following credit card information. Please mail me a receipt on the first of each month.

_____ _____ _____
Credit card type Credit card # Exp. Date

_____ _____
Print Name (as it appears on card) Signature

☐ If I qualify, I wish to take advantage of financial arrangements through a third party finance company, including up to 12 months of interest free financing. *(Applications are available and can be processed today before you leave.)*

Patient Name (Please print) _____ _____ _____
Last Name M.I. First Name

Guarantor: (If patient is a minor) _____ _____ _____
Last Name M.I. First Name

Signature of Patient or Guarantor:_____