

Merrifield Dental

Dr. Jerry Kim and Dr. Edison Abril
8622 Lee Highway, Ste. A
Fairfax, VA 22031

Date: _____

Insurance Co.: _____

Pt. Name: _____

Financial Agreement

I, the undersigned, hereby agree to pay to the above named doctor all fees due him for services rendered and/or expenses incurred by me, my spouse or any of my children or dependents. Payment is to be made at the time of service or incurring of expenses.

I understand that the payment of my bill is my legal obligation as the patient. All filings of insurance papers and confirmation of eligibility of benefits and/or confirmation of insurance payments to be made by my insurance company are my responsibility. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow-through or confirmations.

If this account is placed in the hands of an attorney for collection, I understand and agree that I will be responsible for all fees and cost incurred from the attorney, courts and collection agency. The terms herein are reaffirmed each time services are received. I further agree to pay returned check charges of \$50 per returned check.

Undersigned further agrees to pay a charge of \$50.00 when canceling an appointment with less than 48 hours notice.

Signature _____

Date _____