## **Miracle Dental Associates, LLC**

## **Financial Agreement**

Last Name:		First Name:	Date of Birth:
•	payment directly from them.		
•			
•	Every effort will be made to help me with my insurance, but if insurance does not pay as expected, I will still be responsible for any outstanding balances.		
•	will pay a fee of \$25.00 for any single appointment broken without 48 hour notice.		
•	Treatment plans may change, and I will be responsible for the work actually done.		
Patier	nt / Guardian Signature:		Date: