FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

Patient's name: _____
First MI Last

Patient's date of birth: _____ / _____ / _____

I, _____ (name of person responsible for payment) authorize treatment of the person named above and agree to pay all fees and charges for such treatment until the patient turns _____ years of age.

I agree to pay all charges promptly unless credit arrangements are agreed upon in advance. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 (thirty) days of the statement date.

NOTICE: Do not sign this agreement before you agree to the conditions set forth. You are entitled to a copy of this agreement.

Signature: _____ Date: _____
Signature of Person Responsible for Payment