

**Lawn Dental Center
3113 S. Pulaski Rd.
Chicago, IL. 60623**

“I understand and agree that dental insurance policies are an arrangement between my insurance company and myself-not my insurance company and this office. I authorize this office to release any dental information and to complete any usual and customary reports and forms at no charge, to assist in collecting from my insurance company”

“However, I understand that I am ultimately responsible for payment in full at this office and agree to pay a 10(ten) dollar per month billing charge and a 2.0(two) percent monthly interest for all unpaid balances at least 30(thirty) days past due. If necessary, I also agree to take full responsibility for all third party costs, including collection agencies, reasonable attorney fees and/or court costs incurred in attempting to collect this debt.”

“I have read this financial policy. I understand and agree to all the terms of this policy.”

Patient's Signature