Michael V. Razzano D.D.S.
A Family Dental Practice

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor /child. I accept full financial responsibility for all charges for services or items provided to me or patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. I also understand that if my account becomes delinquent and is turned over to a collection agency, I will be charged a collection fee.

_____ _____
Signature of Patient/Parent, guardian or personal representative Date

_____ _____
Print name as signed above Relationship to patient