FINANCIAL POLICY

1. I understand that if I do not pay my account with Carson City Pediatric Dentistry in full and on time that my account may be assigned to a collection agency for collection of the debt.
2. I understand that if my account is assigned to a collection agency, the collection agency will charge a commission fee that may be as much as 40% of the amount I owe to Carson City Pediatric Dentistry. I also agree that if my account is assigned to a collection agency, Carson City Pediatric Dentistry may add the collection agency's commission fee to the amount I owe and I agree to pay the additional 40% fee.
3. I understand that the addition of the collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for dental services. For example, if the unpaid balance I owe is $1000.00, Carson City Pediatric Dentistry may add up to $400.00 to my account and I agree to pay that sum in each event.
4. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and attorney fees assessed.

Print Patient Name: _____

Signature of Patient/Guarantor: _____

Date: _____