FINANCIAL AGREEMENT

Candace M. Opon D.D.S. Ltd.
College Hill Professional Building
690 N Route 31, Suite G
Crystal Lake, IL 60012

Name of Patient

AUTHORIZATION

I hereby authorize payment directly to the office of Candace M. Opon D.D.S. for insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the dental treatment.

I grant the right to the dentist to release my dental histories and other information about my dental treatment to third party payors and/or other health professionals

SERVICE CHARGE

If I do not pay the entire balance within 60 days, a service charge will be added to the account for the current billing period of 1.5% per month, or, in the case of a budget plan, I agree to pay a fee per month for late payment after the 15th. In case of default payment, I agree to pay any legal fees and interest on the balance due, together with any collection costs and attorney's fees incurred to effect collection on this account or future outstanding accounts

Patient Signature (Parent, if minor)

Date

WE ACCEPT CASH, CHECK, MASTERCARD AND VISA