

**Financial Agreement**

**Alaska Center for Dentistry  
C. Michael Sage Jr., DDS  
418 N. Main Street  
Wasilla, AK 99645  
(907) 373-8455**

**Financial Agreement and Authorization for Treatment**

**Note: We wish to stress that the financial Responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. Most of the time our fees fall within their "usual and customary" guidelines; however, the responsibility for the balance of this account falls on you. If any overpayment is received it will be refunded to you. Should your account become 60 days past due, a .86% interest charge can be applied to your account.**

**I hereby authorize the release of any dental or financial information necessary to process claims for services rendered.**

**In the event legal action should become necessary to collect an unpaid balance for dental services to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the Court determines proper.**

**I authorize treatment of the named patient and agree to pay all fees and charges for such treatment. Regardless of what my insurance pays, I will pay for the balance in full.**

**I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balances on my account.**

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**Patient/Guardian Signature**

**Witness Signature**

**Date: \_\_\_\_\_**

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