Family and Implant Dentistry
Thomas E. Condron, D.D.S.
Ameena Syed, D.D.S.
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Financial Agreement

PROMISE TO PAY ACCOUNT: In Consideration of **FAMILY AND IMPLANT DENTISTRY, THOMAS E. CONDRON, D.D.S.** furnishing services and supplies to the above-named patient, I agree to pay **FAMILY AND IMPLANT DENTISTRY, Thomas E. Condron, D.D.S.,** its agents and assigns, all sums of money which shall become due on the account of the above-named patient with the dental office in accordance with its regular rates and terms. I understand that this agreement in no way relieves any such other party of any obligation to pay this account. I agree to pay all bills for dental/medical services rendered either through my insurance company or by being individually responsible for payment of any dental/medical services which are not covered by my insurance policies; including services my dental/health plan determines to be not medically necessary of experimental/investigational. I understand and agree that the account is due in full upon discharge with allowances made for insurance coverage approved and verified prior to discharge. **I also understand that I will be charged interest in the amount of 8.0% per annum for any unpaid balances over 30 days old. The unpaid balance on the account will be paid within 45 calendar days.**

PLEASE READ BEFORE SIGNING.

_____
Print Name

_____
Signature

_____
Date

It is your responsibility to appropriately notify your insurance company.