Financial Responsibility Agreement

I (We) assume personal responsibility for and guarantee payment of all sums due and payable to Bruening Dental, LLC.

I (We) also assume personal responsibility for and guarantee payment for any minor child that I (We) accompany during this visit; regardless of any agreement I (We) may have with any other parent or guardian of the minor child.

I (We) authorized Bruening Dental, LLC and any collection agency and/or attorney which Bruening Dental, LLC may forward my (our) account for collection, to contact me (us) at any telephone number that I provide or obtained through any public information source or record.

I (We) understand that interest is charged on overdue accounts at the monthly rate of 5% and I (We) will be responsible for all costs of collection including collection and/or attorneys' fees.

I (We) acknowledge that a fee of $50.00 is charged for patients who miss or cancel appointments without more than 48 hour notice. We strive to respect the time committed by our patients and hope that you will respect the time we have allotted for you as well.

Print Name: ____

Accepted and Agreed: ____________________________________ Date: ____________

Accepted and Agreed: ____________________________________ Date: ____________

If you would like a copy of this agreement, please ask our office staff to provide you with it.