

**FINANCIAL AGREEMENT: PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED**

I accept financial responsibility for all goods and services rendered to the patient named above and to accept the terms of the Financial Agreement, Assignment of Benefit, and Release of Information provisions above.

I have read and agree to the terms above:

\* \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**Signature of patient or legal guardian**

**Date**