Kevin A. Harrison, DDS,PS
16410 Smokey Pt. Blvd. #305
Arlington, WA 98223
360-653-7654
www.kevinaharrisondds.com

Financial Agreement and Authorization for Treatment

I authorize Kevin A. Harrison, DDS, PS to provide dental treatment for myself or my dependent named below and agree to pay all fees and charges for such treatment. Payment for services is due at the time services are provided unless other financial arrangements have been approved in advance by our staff. We accept cash, check, Visa and MasterCard. We also work with CareCredit, a company that provides financing for dental care. A fee of $30 will be charged for all returned checks. We reserve the right to charge a broken appointment fee for any appointments cancelled without 48 hours advance notice.

We will assist you by processing all your claim forms at no charge and will accept assignment of benefits to be paid directly to our office. In this situation, we will estimate the amount of coverage and determine your balance due. I understand this is only an estimate and agree I am responsible for any balance due.

Accounts more than sixty days past due will be assessed a service fee of 1.5% per month of the balance due with a $2.00 minimum. Should it become necessary to place my account with an outside agency for collection, I agree to pay all collection fees. Should legal action be filed, I agree to pay any costs deemed proper by the court.

I have read and understand the above agreement.

Patient Name_____

Responsible Party_____

Signature_____Date_____