



Dr. Purnima Hernandez & Dr. Selin Soyupak
23-00 Route 208, Suite 2-5,
Fair Lawn, NJ, 07410

Financial Agreement

I hereby authorize and guarantee payment for all services rendered.

- 1) **All** fees for services are **due** and payment expected at the time services are rendered.
Please initial here: _____
- 2) For any **balance** remaining, I acknowledge that payment is due and expected at the time the billing statement is received. **Please initial here:** _____
- 3) I also acknowledge that although the copay may be collected, it is only an estimate. Any balance amount not paid by the patient's insurance, patient/guardian is responsible for payment of the full balance. **Please initial here:** _____
- 4) Any balance on account not paid will be submitted to a collection agency.
Please initial here: _____
- 5) Parents of Minor Patients: The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Bergen Pediatric Dentistry will not be involved with separation or divorce disputes. **Please initial here:** _____

Thank you for taking the time to review Bergen Pediatric Dentistry's policies. Please feel free to ask any questions or share with us special concerns.

By willingly signing below, I am agreeing that I have read and understand the above statements and I agree to the terms.

Print Name: Responsible Party

Signature: Responsible Party

Date