Financial Consent

The patient (or person with financial responsibility for the account) agrees to be fully responsible for total payment of treatment performed in this office.

I authorize Riversbend Dental Springdale to leave messages regarding my account, including but not limited to, any balance due on the following # _____

Names of patients that are responsibility of the signer (please print):

_____

_____

_____

_____ _____

Signature of patient (or responsible party) Date