



John J. Schymanski, D.D.S.
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Patient Financial Responsibility Agreement

I hereby authorize the assignment of any insurance benefits to the dentist and agree to be liable for the payment of all dental services performed and not paid by insurance or other benefits. I also agree to pay interest there-on at 1-1/2% per month (18% per annum) on any balances left due and owing.

I also agree to pay all collection costs and reasonable attorney fees in the event this account or any future account of mine is turned over to the attorneys representing Forest Ridge Family Dentistry for collection, all without relief from valuation and appraisal laws should I fail to pay any amounts not paid by insurance or other benefits.

I consent to allow Forest Ridge Family Dentistry, or its agents, to contact me via call or text on my cell phone regarding appointments, treatment, insurance, and my account. I understand I can withdraw this consent at any time.

Signature

Print

Date