



Financial Responsibility Agreement

I (We) assume personal responsibility for and guarantee payment of all sums due and payable to Andrew R. Bruening DDS, LLC.

I (We) also assume personal responsibility for and guarantee payment for any minor child that I (We) accompany during this visit; regardless of any agreement I (We) may have with any other parent or guardian of the minor child.

I (We) authorized Andrew R. Bruening DDS, LLC and any collection agency and/or attorney which Andrew R. Bruening DDS, LLC may forward my (our) account to for collection, to contact me (us) at any telephone number that I provide or obtained through any public information source or record.

I (We) understand that interest is charged on overdue accounts at the monthly rate of 5% and I (We) will be responsible for all costs of collection including collection and/or attorneys' fees.

I (We) acknowledge that a fee of \$35.00 is charged for patients who miss or cancel appointments without more than 24 hour notice. We strive to respect the time committed by our patients and hope that you will respect the time we have allotted for you as well.

Print Name: _____

Accepted and Agreed: _____ Date: _____

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If you would like a copy of this agreement, then please ask our office staff to provide you with it.