



Scott H. Leaf, D.D.S., Burke PLC



PEDIATRIC DENTISTRY
9316-C OLD KEENE MILL ROAD
BURKE, VA 22015

FINANCIAL AGREEMENT

We are delighted to have your children as our patients and are providing this agreement in order to clearly define financial responsibilities for your children's dental care. Our practice is committed to providing the best treatment for our patients while charging what is fair and reasonable in this area. As a parent or guardian, you are responsible for your children's dental bill and/or for that portion that for any reason may not be covered by certain Delta Dental, United Concordia, Aetna or MetLife insurances. We do not accept or file any other insurance. The office will provide you with all of the information necessary for you to file your claim with your insurance carrier.

Fees are collected at the time of service unless the treatment plan calls for an orthodontic appliance for which other arrangements may be made. Any other charges are due upon receipt.

AGREEMENT OF TERMS

I agree to pay for all costs of the services rendered to my children, and I further agree to pay for the service at the time service is rendered. I understand that you will, as a courtesy only, file all claims for dental services if I am covered by certain Delta Dental, United Concordia, Aetna or MetLife insurances, or will provide me with the information I need to file with any other insurance company for my reimbursement.

If my account becomes assigned to a collection agency or attorney, I agree to pay all costs of collection, including agency fees, court costs, filing fees, and 100% attorney's fees.

Returned checks are subject to a \$35 fee.

Signature & Relationship to Patient: _____

SSN#: _____

Date: _____

The person that is financially responsible for this account needs to sign this form