FINANCIAL AGREEMENT

Patient____ Date________________________
(Print Name)

Guarantor's Name (if other than patient) ____
(Print Name)

I agree to pay the amount of $________________________ to Aaron Elkowitz, DMD, P.C.

for dental services described to me on _____________________________.
(Date)

Payment Arrangements ____

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I understand that as the treatment progresses modifications may be necessary and these may affect the fee. Should this occur, I further understand, that the modification of treatment, and the changes in fee will be discussed with me at the earliest possible time.

Signature of Patient or Guarantor ____________________________________Date_____________