

Michael E. Anderson, D.D. S.

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Financial Responsible

The undersigned hereby acknowledges that he/she is financially responsible for any insurance deductible, co-insurance, or failure for any reason of any insurance carrier, when applicable, to pay the charges in full when rendered. The undersigned also agrees, whether he/she signs as an agent or patient, he/she is obligated for the payment of all outstanding services rendered to the patient which are due when rendered. The undersigned accepts full financial responsibility if incorrect insurance information or failure to provide such information results in a denial of claims and further understands and acknowledges that it is the responsibility of the undersigned to know and understand the insurance plan of the patient or the undersigned.

Patient, Parent or Guardian's Signature

Date

Please Printed Name

Witness