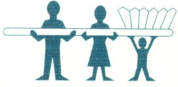

KELVIN B. SMITH, D.D.S., LLC
7008 Security Boulevard, Suite 110
Baltimore, MD 21244
(410) 277-9206
(410) 277-9209 Fax

FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible dental care. In order to begin a long-lasting professional relationship, we ask for your understanding of, and cooperation with, our financial responsibility policy.

Please read, sign and date this form to acknowledge your understanding of your financial relationship with our office.

I, the undersigned, hereby agree to pay the above named dentist(s) all fees due him/her for services rendered. Payment is to be made at the time of service unless alternative arrangements have been made in advance.

I understand that the payment of my bill is my legal obligation as the patient. I understand that the relationship with my insurance company is between the insurance company and myself and not the dental office. All filings of insurance papers and confirmation of payments to be made by my insurance company, are my responsibilities. Any and all assistance in this matter granted by the above dentist and/or staff is given strictly as a courtesy and implies no responsibility on their part(s). This includes confirmation of coverage, filing of claims and follow through.

I understand that if my account is placed in the hands of an attorney and /or collection agency, I agree to pay all attorney fees and all collection fees. In the event of a returned check, I agree to pay a $35 returned check fee.

____

Signature   Date