

FINANCIAL AGREEMENT

JOHN R. HENDRICKS, JR., D.D.S.

3245 Peachtree Parkway, Suite H
Suwanee, GA 30024

Telephone: (770) 886-7000

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____	_____
Signature of Patient, Parent, Guardian or Personal Representative	Date
_____	_____
Please print name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient