

Family Dental Associates  
Randy Hestir, DDS & Doug Allen, DDS  
1703 S. Whitehead Dr.  
P.O. Drawer 512  
DeWitt, AR 72042

Family Dental Associates  
Financial Agreement

**PROMISE TO PAY ACCOUNT** : In Consideration of FAMILY DENTAL ASSOCIATES furnishing services and supplies to the above-named patient, I agree to pay FAMILY DENTAL ASSOCIATES, its agents and assigns, all sums of money which shall become due on the account of the above-named patient with the dental office in accordance with its regular rates and terms. I understand that this agreement in no way relieves any such other party of any obligation to pay this account. I agree to pay all bills for medical services rendered either through my insurance company or by being individually responsible for payment of any medical services which are not covered by my insurance policies; including services my health plan determines to be not medically necessary of experimental/investigational. I understand and agree that the account is due in full upon discharge with allowances made for insurance coverage approved and verified prior to discharge.

**READ BEFORE SIGNING.**

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Print Name

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Signature

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Date

It is your responsibility to appropriately notify your insurance company.