WILLIS GENERAL DENTISTRY, PLLC

Please read and understand prior to being treated.

Date:__________________________________

I,______________________________________, promise to be responsible for the unpaid balance from all visits with Willis General Dentistry, PLLC. Payment is due at the time of your visit. If for any reason Medicaid or my personal insurance does not pay the balance of the bill, then this balance will be due 15 days after a financial statement has been mailed from this office. If for any reason this account is placed into collections I will be responsible for all collection costs, including court, filing, and attorney fees. Fees charged on date of service are only an estimate of a patient with insurance charges and additional charges may be billed to the patient for charges unpaid by the insurance company. **Any patient with dental insurance is responsible for his/her entire bill and will receive a mailed statement for any balance unpaid by his/her insurance company.** Please remember patients will be charged a $25 fee for appointments broken or cancelled with less than 24 hours notice. If you must reschedule an appointment please do it as soon as you know that you can't make that appointment.

____
(Patient or Responsible Party)

____
(Witness)

SHELDON WILLIS, DDS
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