Jonathan S Judd, DDS & James R Mengert, DDS

Financial Agreement

Last Name: First Name: DOB:

Please give us 24 hours' notice if changing appointments
Our Office charges a fee for last minute cancellations and broken appointments.

I hereby authorize payment directly to Drs. Jonathan S. Judd, and James R. Mengert from insurance benefits otherwise payable to me for services rendered.

I understand that it is my responsibility to know my insurance coverage and I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted providers or supplier of services in this office to release any information required to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

I understand that my portion of fees, anticipated not to be paid by insurance, are due at the time of service.

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Signature of Responsible Party Date: