SOUTH COVE COMMUNITY HEALTH CENTER

DENTAL DEPARTMENT

Patient Payment Agreement

Patient Name: _____ MRN #: _____

Name of Procedure: _____ ADA Code: _____

TOTAL AMOUNT:$ _____ _____ Self _____HSN

Signature of Patient: _____ Date: _____

Signature of Dentist: _____ Dental Assistant: _____

I understand that I will be financially responsible for the charges not covered by HSN.

如果減費計劃(HSN)不包括以上費用，將由本人負責付款。

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1. Date: _____ $ _____= $ _____ _____
   Amt Received Balance Received By
2. Date: _____ $ _____= $ _____ _____
   Amt Received Balance Received By
3. Date: _____ $ _____= $ _____ _____
   Amt Received Balance Received By
4. Date: _____ $ _____= $ _____ _____
   Amt Received Balance Received By
5. Date: _____ $ _____= $ _____ _____
   Amt Received Balance Received By

Payment Completion Date: _____

Signature of Patient: _____