

FINANCIAL AGREEMENT

Patient

(Print Name)

Date

Guarantor’s Name (if other than patient)

(Print Name)

I agree to pay the amount of $ to Aaron Elkowitz, DMD, P.C.

for dental services described to me on .

(Date)

Payment Arrangements

I understand that as the treatment progresses modifications may be necessary and these may affect the fee. Should this occur, I further understand, that the modification of treatment, and the changes in fee will be discussed with me at the earliest possible time.

Signature of Patient or Guarantor Date

**561 Hempstead Avenue, West Hempstead, NY 11552 516-483-7580** [**www.WESTHEMPSTEADDENTAL.COM**](http://www.WESTHEMPSTEADDENTAL.COM/)