Douglas S.M. Callis, D.M.D.
515 Old Toll Rd.
Madison, CT 06443

Patient Financial Responsibility Agreement

I understand that I am responsible to know what my insurance covers and what portion of the bill will be my responsibility.

I understand that payment for services is due the day services are rendered, and that all balances owed by me must be paid in full within 30 days from the date of my bill. I know I am responsible for any amount not paid or covered by my insurance.

I understand that I am responsible for any fees resulting from an unpaid balance or a returned unpaid check from my bank, and that there will be a returned check charge of $25.00.

I understand if I fail to give 24 hour notice of cancellation of any appointment associated with my account, I will be responsible for a charge of $25.00 per missed appointment.

Patient Name: _____

Signature of Patient/Guardian: _____

Date: _____