DOUGLAS S.M. CALLIS, D.M.D.

515 Old Toll Rd.

Madison, CT 06443

203-421-4100

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 rendered is due the day the service is performed, and that all balances owed following insurance submission must be paid in full within 30 days. I know I am responsible for any amount not covered by 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 that if I fail to give 24 hours notice of cancelling an appointment associated with my account, I will be charged a missed appointment fee of $50.00 per each missed appointment.

Patient Name: _____

Signature of Patient/Guardian: _____

Date: _____