Eastview Dental Professionals 24 Eastview Road Averill Park, NY 12018

First Name	Last Name	DOB	Date
Office and Financial Policie	es Agreement		
patients understand and pla The following is a statement	ships with a deep sense of respons in for their oral health along with pro t of Drs. Gamache, O'Brien and Lou to, and sign the agreement before	oviding each patient the uie's Office Policies and	highest quality of dental care. Financial Agreement. We ask
offer a choice of No Interest partner. If you would like to filling out an application form in excess of 60 days are sul	check, MasterCard, Visa, Discover, or Extended Payment Plans to qua make extended payments for servin. If you do not have insurance, payiect to a finance charge of 1.5% peot a third party collection agency.	alified applicants throug ices provided at our offic syment in full is expected	h Care Credit, our financial ce, please ask for assistance in d at the time of service. Balance:
		_	[Initial]
Additional Charges A fee of \$36.00 will be char	ged on all returned checks.	_	[Initial]
Release of Information I authorize Geoffrey R. Gan regarding my dental/medica	nache DDS, Christina T. O'Brien DI al history, diagnosis, or treatment to	DS, and Lauren Louie, E third-party payors and/	OMD to release any information or other health professionals.
		-	[Initial]
	insurance company to pay my ben	efits directly to Geoffrey	R. Gamache, DDS, Christina T.
O'Brien, DDS, and Lauren I	Louie, DMD where applicable.		[Initial]
	Sign	ature	